Kansas
Department of Health and Environment
Division of Health Care Finance

STATE EMPLOYEE HEALTH PLAN
ADMINISTRATIVE MANUAL – NON STATE EMPLOYERS
PLAN YEAR 2011

CHAPTER 1 – GENERAL HEALTH PLAN INFORMATION

I. GENERAL HEALTH PLAN INFORMATION

The State Employee Health Plan (SEHP) is authorized by K.S.A. 75-6501 et seq. The program is governed by the State of Kansas Employees Health Care Commission (HCC) which is comprised of the following five members:

- The Secretary of the Kansas Department of Administration
- The Kansas Insurance Commissioner
- A retiree from classified State of Kansas service (appointed by the Governor)
- An active employee from classified State of Kansas service (appointed by the Governor)
- A person from the general public (appointed by the Governor)

The HCC has created a Non State Employer (NSE) health care benefit plan to provide health care benefits within the SEHP benefits program. The intent of this is to allow the NSE to participate in a health benefit risk pool, which is comprised of entities enumerated in K.S.A. §75-6506(c) and other amendments. The HCC and SEHP Commission provide professional benefit administration of the health plan.

Generally, the State of Kansas bids and contracts with health plans for three year periods. The component parts (medical, prescription drug, dental and vision) are staggered so that not all contracts come due the same year.

All State Employee Health Plan medical plans for active employees are self insured. These include:

- Blue Cross Blue Shield (Plan A and Plan B),
- Coventry Health Care of Kansas (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account),
- Preferred Health Systems (Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)
- UMR, A UnitedHealthcare Company(Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)
- The prescription drug program is self insured with Caremark contracted as the prescription benefit manager.

Other health plan benefits available under the SEHP:

- The dental plan is self insured and administered by Delta Dental Plan of Kansas.
- The voluntary vision plan is fully insured by Superior Vision.
- COBRA (Consolidated Omnibus Budget Reconciliation Act) administered by CobraGuard

For each self insured plan, the SEHP pays the plan provider an administrative fee per contract to process membership and claims. The SEHP and plan members are therefore directly responsible for all claims and utilization costs.

II. GENERAL DEFINITIONS

A. COBRA Participant—a participant who elects a temporary extension of health coverage where such coverage would otherwise end as defined by the COBRA act of 1986.

B. Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) —a Federal law requiring that most employers sponsoring Group Health Insurance Plans offer employees and their families an opportunity to extend health coverage for a limited period of time.

C. Direct Bill and Retirees—a program to extend health coverage to: 1) retiring participating non state employees, 2) totally disabled former participating non state employees, 3) surviving spouses and/or dependents of participating non state employees eligible under the provisions of K.A.R. 108-1-3and 108-1-4 and 4) active participating non state employees who were covered under the health plan immediately before going on approved leave without pay.

D. Educational Employer Group (See also Qualified School district)—a public school district, community college, area vocational technical school, or technical college that meets the terms, conditions and other provisions established by the HCC and has entered into a written agreement with the HCC to participate in the SEHP.

E. Employee Contribution Rate—the amount of the premium paid by the non state employee for their SEHP coverage.

F. Employer Contribution Rate—the amount of the premium paid by the employer on behalf of the employee and/or dependents.

G. Full-time Educational Employer Group (Qualified School District) Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 1,004 hours of work per year.

H. Full-time Local Unit Employee—the individual is an appointed or elective officer or employee of a qualified local unit whose employment sis not seasonal or temporary and whose employment requires more than 2,000 hours of work per year.

I. Health Care Commission (HCC)—the entity that establishes and oversees all provisions under the State Employee Health Plan.

J. Health Plan—defined medical, drug, dental and vision benefits offered to non state employees under the State Employee Health Plan.

K. HealthQuest—the State of Kansas Health Promotion Program, which is a wellness program administered by the State Employee Health Plan.

L. Local unit or entity—any of the following:

1) Any county, township, or city

2) Any community mental health center;

3) Any groundwater management district, rural water-supply district, or public wholesale water-supply district;

4) Any county extension council or extension district;

5) Any hospital established, maintained, and operated by a city of the first or second class, a county, or a hospital district in accordance with applicable law;

6) Any city, county, or township public library created under the authority of K.S.A. 12-1215 et seq., and amendments thereto;

7) Any regional library created under the authority of K.S.A. 12-1231, and amendments thereto;

8) Any library district created under the authority of K.S.A. 12-1236, and amendments thereto;

9) The Topeka and Shawnee county library district established under the authority of K.S.A. 12-1260 et seq., and amendments thereto;

10) The Leavenworth and Leavenworth county library district established under the authority of K.S.A. 12-1270, and amendments thereto;

11) Any public library established by a unified school district under the authority of K.S.A. 72-1623, and amendments thereto; or

12) Any regional system of cooperating libraries established under the authority of K.S.A. 75-2547 et seq., and amendments thereto;

13) Any housing authority created pursuant to K.S.A. 17-2337 et seq., and amendments thereto;

14) Any local environmental protection program obtaining funds from the state water fund in accordance with K.S.A. 75-5657, and amendments thereto;

15) An city-county, county, or multicounty health board or department established pursuant to K.S.A. 65-204 and 65-205, and amendments thereto;

16) Any nonprofit independent living agency, as defined in K.S.A. 65-5101 and amendments thereto;

17) The Kansas guardianship program established pursuant to K.S.A. 74-9601 et seq., and amendments thereto; or

18) Any group of persons on the payroll of a county, township, city, special district or other local governmental entity, public school district, licensed child care facility operated by a not-for-profit corporation providing residential group foster care for children and receiving reimbursement for all or part of this care from the department of social and rehabilitation services, nonprofit community mental health center pursuant to K.S.A. 19-4001 et seq. and amendments thereto, nonprofit community facility for the mentally retarded pursuant to K.S.A. 19-4001 et seq. and amendments thereto, or nonprofit independent living agency as defined in K.S.A. 65-5101 and amendments thereto.

M. Local unit/entity plan—the local unit/entity employee health care benefits component of the heath care benefits program.

N. Member—individual who is eligible for and actively participates in the health care benefits offered through the State Employee Health Plan.

O. Membership Services—the unit in the State Employee Health Plan that is responsible for all daily management of all eligibility functions and membership activities for all members who participate in the State Employee Health Plan. Members include Active state employees, Non-State Public Employer Group employees, Retirees, Direct Bill members and COBRA participants. The unit is also involved in managing and securing contracts with vendors that provide administrative services related directly to Membership programs.

P. Non State Health Benefits Risk Pool—a defined group of employees that are experience rated.

Q. Open enrollment period--refers to the period of time during which all members of the SEHP have the opportunity to enroll in and make plan changes to their SEHP. Open enrollment is only held once a year during the month of October. If a member misses the SEHP's annual open enrollment period, the member will not be able to enroll in or make any plan changes to their SEHP coverage until the next annual open enrollment period. Certain exceptions apply for new employees or employees with midyear qualifying events.

R. Part-time Educational Employer Group (Qualified School District) Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 630 hours of work per year.

S. Part-time Local Unit Employee—the individual is an appointed or elective officer or employee of an educational employer group whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year.

T. Plan year—annual time period for benefits in the SEHP. Begins at 12:01 a.m., Central Standard Time, on January 1, through midnight, December 31.

U. Premium—the total cost of the health plan option selected by the employee.

V. Qualified school district—a public school district, community college, area vocational technical school or technical college that meets the terms, conditions and other provisions established by the HCC and has entered into a written agreement with the HCC to participate in the SEHP.

W. Ramp Up—the alternative method for an employer to reach the funding level that is at least equal to the contribution made for State employees and dependents in the SEHP.

X. School district plan—the school district employer health care benefits component of the health care benefits program.

Y. State Employee Health Plan (SEHP) —the state health care benefits program that may provide benefits for persons qualified to participate in the program for medical, prescription drug, dental, vision and other ancillary benefits to participating non state employees and their eligible dependents as defined under the provisions of K.A.R. 108-1-3 and 108-1-4. The program may include such provisions as are established by the Kansas state employees health care commission, including but not limited to qualifications for benefits, services covered, schedules and graduation of benefits, conversion privileges, deductible amounts, limitations on eligibility for benefits by reason of termination of employment or other change of status, leaves of absence, military service or other interruptions in service and other reasonable provisions as may be established by the commission.

Questions about the administration of the SEHP should be directed to the following address:

State Employee Health Plan
Membership Services
Room 900 – Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1220
Telephone: (785) 296-3226
Fax: (785) 368-7180
http://www.kdheks.gov/hcf/
benefits@kdheks.gov

NOTE:

Non State Employer Human Resources Representatives must ensure that current valid employee addresses are on file with SEHP Membership Services. It is important that current addresses are maintained by the SEHP so that employees can receive health plan information timely.

The Appendices of this manual contain the current forms and other important information.

If you have specific questions regarding areas within the SEHP, please contact the respective staff in the table on the next page.

Kansas
Department of Health and Environment
Division of Health Care Finance

2011 STATE EMPLOYEE HEALTH PLAN CONTACT LIST

MEMBERSHIP SERVICES			
Judy Crawford	Sr. Admin. Assistant	785-296-3226	JCrawford@kdheks.gov
Cindy Miller	Senior Manager	785-368-6578	CAMiller@kdheks.gov
NON STATE EMPLOYER (NSE) GROUPS			
Alicia Thurlow	Benefits Consultant—NSE Specialist	785-296-5443	AThurlow@kdheks.gov
Eilene Wason	NSE COBRA Specialist	785-296-4459	EWason@kdheks.gov
Zaq Rood	Benefits Consultant	785-368-6341	ZRood@kdheks.gov
HP Enterprise Services	Premium Billing vendor	866-688-5009	https://express.openbill.com/khpa/enroll.html
COBRA ENROLLMENT			
Sarah Beck	Benefits Consultant—COBRA/Communications	785-296-0880	SBeck@kdheks.gov
Eilene Wason	COBRA Specialist	785-296-4459	EWason@kdheks.gov
COBRAGuard	COBRA billing vendor	866-952-6272	participant.services@cobraguard.net
DIRECT BILL ENROLLMENT			
DIRECT BILL Phone Line		866-541-7100 (Toll Free) 785-296-1715	
Deb Dumas	Direct Bill Specialist	785-291-3126	DDumas@kdheks.gov
Stephanie Wywadis	Direct Bill Specialist	785-291-3264	SWywadis@kdheks.gov
HP Enterprise Services	Premium Billing vendor	866-688-5009	https://express.openbill.com/khpa/enroll.html
SEHP PROJECT COORDINATOR – SEHP WEBSITE MANAGEMENT			
Laurie Knowlton	Project Coordinator	785-296-6280	LKnowlton@kdheks.gov
HEALTH PLAN OPERATIONS			
Melody Connell	Benefits Consultant	785-368-6533	MConnell@kdheks.gov
Jeanne Kelly	Benefits Communication Manager	785-296-6205	JKelly@kdheks.gov
HEALTH PLAN DESIGN/FISCAL AND DATA MANAGEMENT			
David Bollig	Health Plan Analyst	785-296-4084	DBollig@kdheks.gov
Delos DeCelle	Senior Manager	785-296-3667	DDeCelle@kdheks.gov
HEALTH MANAGEMENT (WELLNESS)			
Julie Faust	Wellness Communications Coordinator	785-296-5624	JFaust@kdheks.gov
Cheryl Miller	Senior Manager	785-296-4304	CMiller@kdheks.gov

http://www.sehbp.org/state-employee-health-plan-home--2/non-state-employer-groups

CHAPTER 2 - NON STATE EMPLOYER GROUP ELIGIBILITY

I. NON STATE EMPLOYER GROUP DEFINITION

As defined by the HCC, Non State Employer groups may include, but are not limited to the following: qualified school districts, community colleges, area vocational technical schools, or technical colleges, special districts or other local governmental unit or entity; persons on the payroll of a county, township, city, county extensions, hospitals (city, district, or community), libraries, and community mental health centers as outlined in Supp. 2005 K.S.A. 75-6506(c) and supporting regulations.

II. PARTICIPATION REQUIREMENTS

In order for a Non State Employer to qualify to participate in the SEHP:

A. A minimum of 70 percent of all benefits eligible employees must be enrolled in the SEHP. Non State Employers will certify their compliance with the 70 percent enrollment each year.

B. Plan design and funding are determined by the HCC and are not subject to negotiation.

C. The State requires Non State Employers to sign a contract to participate for a minimum of 3 years. If the Non State Employer qualifies for a financial option (premium ramp up), the participation in the plan is required for a minimum of five years.

D. Non State Employers may not create, maintain or provide incentives for employees not to join the SEHP. Non State employers may not permit any exemption from participation in the SEHP for their group's employees. This prohibition includes Internal Revenue Code Section 125 cash out options.

E. The SEHP must be considered a "core" benefit in the Non State Employer's cafeteria benefit plan.

F. The rate of the premium paid by the Non State Employer shall at least equal the rate paid by the State of Kansas for its employees.

G. Non State Employers must contribute toward and participate in HealthQuest, the state's health wellness program. Each employer must provide a contact person and must participate in HealthQuest initiatives.

H. Non State Employers must provide staff for enrollment, general information and first level assistance to employees and members.

I. Non State Employers must adhere to the established administrative processes and procedures set up by the Health Care Commission.

J. Non State Employer groups joining the SEHP after the beginning of the Plan Year

will incur the plan deductibles and coinsurance beginning on the effective date of the group in the plan. Deductible and coinsurance do not carry over and must be met for each Plan Year (January 1-December 31).

NOTE: PLEASE REFER TO THE "STATE OF KANSAS NON STATE PUBLIC EMPLOYER CONTRACT" FOR ADDITIONAL REQUIREMENTS AND PROVISIONS.

CHAPTER 3 - EMPLOYEE ELIGIBILITY

I. EMPLOYEE DEFINITION—ACTIVE PARTICIPANTS

According to provisions of K.A.R. 108-1-3 (see **Appendix A-1**) and K.A.R. 108-1-4 (see **Appendix A-2**), the classes of persons eligible to participate in the State Employee Health Plan as Active Participants shall be the following classes of persons:

A. Educational Employer Group/Qualified School District employee—any individual who is employed by an education employer group/qualified school district and who meets the definition of employee under K.S.A. 74-4932(4), and amendments thereto, whose employment is not seasonal or temporary and requires at least:

1. 630 hours of work per year for part-time status or;

2. 1,004 hours of work per year for full-time status

B. Qualified Local unit employee—any individual who meets one or more of the following criteria:

1. The individual is an appointed or elective officer or employee of a qualified local unit whose employment is not seasonal or temporary and whose employment requires at least 1,000 hours of work per year for part-time employees and more than 2,000 hours of work per year for full-time employees.

2. The individual is an appointed or elective officer or employee who is employed concurrently by two or more qualified local units in positions that involve similar or related tasks and whose combined employment by the qualified local units is not seasonal or temporary and requires at least 1,000 hours of work per year for part-time employees and more than 2,000 hours of work per year for full-time employees.

3. The individual is a member of a board of county commissioners of a county that is a qualified local unit, and the compensation paid for service on the board equals or exceeds $5,000 per year.

4. The individual is a council member or commissioner of a city that is a qualified local unit, and the compensation paid for service as a council member or commissioner equals or exceeds $5,000 per year.

Eligible active employees who elect to participate shall be referred to as member(s) throughout the rest of this manual. The term SEHP means the State Employee Health Plan.

II. EMPLOYEE WAITING PERIOD

Each person who is within a class listed in paragraphs A-B above whose first day of work for the qualified school district or local unit is on or after the first day on which the qualified school district or local unit participates in the school district or local unit plan shall become eligible for

coverage following the completion of a 30-day waiting period beginning with the first day of work for the qualified school district or local unit.

Each employee will have 31 days from their first day of employment with a qualified school district or local unit to elect or waive SEHP coverage. For those enrolling in the SEHP, their coverage will be effective the first day of the month following completion of the 30-day waiting period starting from their first day of employment with the qualified school district or local unit. If a new employee misses this deadline, the next opportunity to elect coverage will be during the annual SEHP Open Enrollment period.

Enrollment or Change forms submitted without the appropriate supporting documentation as outlined in **Chapters 4 and 11** will be returned to the Non State Employer via secure email with no action taken by the SEHP. All documentation must be in the English language. The deadline for submitting the Forms will not be extended.

1. The waiting period established above will not apply if all of the following conditions are met:

A. The person is returning to work for the qualified school district or local unit, transferring from another qualified school district or local unit, or is transferring from a position that is eligible for coverage under K.A.R. 108-1-1, K.A.R. 108-1-3 or K.A.R. 108-1-4.

B. Immediately before leaving the prior position, the person was enrolled in and had continuous coverage under the health care benefits program provided by the state of Kansas under K.A.R. 108-1-1, the school district plan under K.A.R. 108-1-3, or the qualified local unit plan under K.A.R. 108-1-4.

C. The break in service between the prior position and the new position does not exceed the following time periods:

1) 30 or fewer calendar days; or

2) 365 or fewer calendar days, if the person was laid off in accordance with the practices of the qualified school district or local unit.

The member must complete a new Enrollment Form. The Non State Employer Human Resources Representative should indicate on the Enrollment Form that the member is a current SEHP member, identify who the current employer is and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

2. The waiting period established above will not apply to any person who, on that person's first day of work for the qualified school district or local unit, is enrolled in the health care benefits program provided by the state of Kansas under K.A.R. 108-1-1, the school district plan under K.A.R. 108-1-3, or the qualified local unit plan under K.A.R. 108-1-4 on any of the following bases:

A. The person has had continuous SEHP coverage under the Direct Bill Program. Please refer to **Chapter 17** for complete information on the Direct Bill Program.

The member must complete a new Enrollment Form. The Non State Employer Human Resources Representative should indicate on the Enrollment Form that the member is a current Direct Bill member and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

B. The person has had continuous SEHP coverage under COBRA. Please refer to **Chapter 19** for complete information on COBRA.

The member must complete a new Enrollment Form. The Non State Employer Human Resources Representative should indicate on the Enrollment Form that the member is a current COBRA member and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

C. The person has had continuous SEHP coverage as a dependent of another member in the health care benefits program.

The member must complete a new Enrollment Form. The Non State Employer Human Resources Representative should indicate on the Enrollment Form that the member had been covered under their spouse's or parent's SEHP coverage, provide the employee's name and include the member's employee identification number. Coverage will be effective the first of the month following the date of hire.

B. Persons who are changing from a non-benefits eligible position to a benefits eligible position with no more than a 3 day break in service will apply calendar days employed in the previous position towards meeting the 30 day waiting period. Credit toward the 30 day waiting period will be given for time served in a non-benefits eligible position if the transfer to a benefits eligible position occurs with no more than a 3 day break in employment.

Note: Student employee positions are non-benefits eligible positions and are considered to be temporary or seasonal; therefore, student employees have the 30 day waiting period when moving to a benefits eligible position.

3. Waiver of the Waiting Period

Under certain circumstances, the 30 day waiting period may be waived under the provisions of K.A.R. 108-1-3 (see **Appendix A-1**) and K.A.R 108-1-4 (see **Appendix A-2**). The chief administrative officer of the qualified school district or local unit must certify in writing, to the Kansas State Employees Health Care Commission (HCC) or its designee that the waiver is being sought for either of the following reasons:

I. The new employee is not entitled to continuation of health benefits under either Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act (COBRA), as amended, or state continuation of coverage laws, K.S.A. 40-2209 and K.S.A. 40-3209 and amendments thereto, and is not covered by or eligible to be covered by another health insurance plan;

II. The new employee is required to have health insurance as a condition of obtaining a work visa for employment in the United States.

The Non State Employer must complete and submit a Request for Waiver of the 30 day Waiting Period Form (see Appendix E) along with the written request for waiver, within 30 days of the date of hire.

If the 30 day waiting period is waived, the employee's contribution must initially be paid on an after-tax basis. An employee may change to the pre-tax premium option effective the first day of the month that their coverage would have become effective without the waiver. If an employee desires to change to the pre-tax option after this period of time, a Change Form must be submitted to the SEHP Membership Services with the original Enrollment Form.

III. EMPLOYEE'S EFFECTIVE DATE OF COVERAGE

The initial enrollment period for the Health Plan is limited. New employees should complete an Enrollment Form (see **Appendix B**) within 31 days of their starting date in a benefits eligible position. The effective date of coverage will be the first day of the month following the completion of the waiting period (see **Appendix P—SEHP Coverage Begin Dates**); providing that the SEHP Membership Services receives the form within 41 days from the date of hire.

For new employees being granted the waiver of the waiting period (see prior section), the effective date of coverage is the first day of the month following the date of hire. If the date of hire is the first day of a month, coverage begins on that day.

For current employees who are changing from a non-benefits eligible position to a benefits eligible position, and who have already served the 30 day waiting period, the enrollment period is 31 days from the date the employee started working in the eligible position. SEHP Membership Services must receive the Enrollment Form within 10 days from the date the Enrollment Form is signed. The effective date of coverage is the first day of the month following the starting date in the eligible position. If the eligible position begins on the first day of the month, coverage begins on that day.

For rehired employees with a break in service of 30 calendar days or less, the effective date of coverage is the first day of the month following the rehire date (if the employee had Health Plan coverage in effect prior to the break in service). If the rehire date is the first day of the month, the coverage effective date will be the first day of that month. If the employee is rehired or reactivated within 30 days, the person must enroll in the same coverage they had previously, unless the person experiences a qualifying event.

Corrected Enrollment Forms will be approved only if completed and received by the SEHP Membership Services before the initial coverage election has taken effect.

IV. PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions. Certificates of Creditable Coverage from other medical plans are not needed.

V. WAIVER OF INSURANCE COVERAGE

If an eligible employee does not elect to enroll in the SEHP, an Enrollment Form must be completed and signed by the employee indicating that they wish to waive SEHP coverage. The Enrollment Form indicating waiving of coverage must be submitted to SEHP Membership Services during the employee's initial enrollment period.

VI. FULL-TIME/PART-TIME STATUS

Employee contributions for group health insurance during the Plan Year are dependent upon full-time or part-time employment status of the position (benefit program code) as outlined below. If the employee is active in more than 1 eligible position, the employment status should be based on the combined FTE (Full-Time Equivalent) for all positions.

Employment Status (first 2 digits of benefit program code)

LF = Full-Time (**FT**) = 90 to 100% FTE
LP = Part-Time (**PT**) = 50 to 89% FTE

Employment status and benefit program code must be changed during the Plan Year whenever the employee changes from a full-time to a part-time position or from a part-time to a full-time position (as outlined above).

Employment status and salary range must be changed during the Plan Year whenever the employee changes from a full-time to a part-time position or from a part-time to a full-time position (as outlined above). If the employment status change takes place on the first day of a month, the new benefit effective date will be the first day of that month. If the employment status change takes place during the month, the effective date will be the first day of the following month. If changes in SEHP coverage result from these employment status changes, the same effective dates shall apply.

VII. HEALTH PLAN SALARY RANGE

The Health Plan salary range is the range in which an employee's annual salary falls within as of January 1 each year. For new employees hired during the Plan Year, the annual salary is as of the employee's date of hire. For current employees with new benefits eligibility, the annual salary is as of the date of benefits eligibility.

Employee contributions for SEHP coverage during the Plan Year are dependent upon the employee's salary range as outlined below. (If the employee is active in more than 1 eligible position, the annual salary range shall be based on the combined salary for all positions):

Annual Salary Ranges (Plan Year 2011) (3rd digit of benefit program code)
Salary Range 1 = Less than $28,000
Salary Range 2 = $28,000 to less than $48,000
Salary Range 3 = $48,000 or more

The salary range should not be changed during the Plan Year unless the employee's salary range changes due to changing from a full-time to a part-time position or from a part-time to a full-time position (see Section VI).

The SEHP is responsible for updating each employee's salary range each year prior to the beginning of a new Plan Year. During the plan year, the SEHP will only change the salary range for an employee if an employee changes from full-time to part-time status or vice versa.

Non State Employer Groups will provide the SEHP Membership Services with updated employee salary tiers changes, via email, on a special ID list by **November 15th** each year. All salary tier changes will be effective as of the beginning of the following Plan Year. If the list is not returned by November 15th, only changes related to a qualifying event will be made for the upcoming plan year.

PLEASE NOTE:

- The Qualified High Deductible Health Plan deduction is not dependent on the salary range of the employee.

VIII. TOBACCO USE STATUS DISCLOSURE

THIS SECTION APPLIES TO ALL ACTIVE NON STATE EMPLOYER GROUP MEMBERS AND DIRECT BILL MEMBERS WHO ARE ALSO ENROLLED IN SEHP OPTIONS PLAN A, B, OR C.

DIRECT BILL MEMBERS ENROLLED IN A MEDICARE SPECIALTY PRODUCT ARE NOT ELIGIBLE FOR THE NON-TOBACCO USE PREMIUM DISCOUNT PROGRAM DUE TO CMS (CENTER FOR MEDICARE AND MEDICAID SERVICES) REGULATIONS.

Employer Group active members that are non-tobacco users or Non State Employer Group active members who are tobacco users and are enrolled in an eligible plan who enroll in and complete the HealthQuest tobacco cessation program are eligible to participate in a premium discount of $40 per monthly pay period.

Direct Bill members that are currently enrolled in an eligible plan that are non-tobacco users or Direct Bill members who are tobacco users who enroll in and complete the HealthQuest tobacco cessation program are eligible to participate in a premium discount of $40 per month.

These members are required to disclose their tobacco use status each plan year. There are 4 options for a member to elect:

1. Disclose that they are not a tobacco user. This election allows the Non State Employer Group active member to participate in the premium discount of $40 each month. (For Direct Bill members, this election allows them to participate in the premium discount of $40 per month.) By selecting this option, the member affirmatively discloses that they will not use tobacco, in any form, during the current plan year. If the member does use tobacco in any form or at any time during the plan year, this may constitute a fraudulent misrepresentation and may subject the member to penalties, which may include, but

not limited to, elimination of the employer contribution to the member's health insurance premium, if such a contribution exists;

2. Disclose that they are a tobacco user. Under this election there are 2 options for the member to choose from:

a. Disclose that they use some form of tobacco and are willing to enroll in and complete the HealthQuest tobacco cessation program to the satisfaction of the State of Kansas Health Care Commission and/or the State Employee Health Plan prior to the end of the current plan year as a condition to obtaining the premium discount. If they do not satisfactorily complete the HealthQuest tobacco cessation program, the member will lose the premium discount.

b. Disclose that they use some form of tobacco but will not enroll in or complete the HealthQuest tobacco cessation program and therefore are not eligible for the premium discount. By making this election the member affirmatively discloses that they are a tobacco user and choose not to participate in the non-tobacco use premium discount for the Plan Year.

3. Member chooses to not disclose their tobacco use status. By making this election, the member chooses not to disclose their status as it relates to tobacco use and as a result by not making a disclosure the member is choosing not to participate in the non-tobacco use discount for the Plan Year. No negative inferences shall be made of the member based on their decision not to disclose their status.

NOTE: Not marking a tobacco use status on the enrollment form is treated as non-disclosure.

When the member discloses non-tobacco use, they understand that even a single instance of tobacco use in any form may constitute a fraudulent misrepresentation on their part and may subject them to penalties which may include, but may not be limited to, elimination of employer contribution to their SEHP premiums.

IX. Termination of Employment

All benefits eligible employees of the Non State Employer Group are set up in the SEHP membership system. Therefore, upon termination of employment, the Participating Group is responsible for completing a Change Form indicating termination, even for those employees who have waived SEHP coverage. Changes will not be made until a completed Change Form is received by SEHP Membership Services. Crossing an employee off the monthly billing statement will not be accepted as fulfilling the Participating Groups responsibility to notify the State of a request for coverage changes. The Participating Group will be responsible for both the employer and employee portion of the premiums that result from failure to provide proper notice to the State in a timely manner. The State's receipt of the Change Form indicating termination triggers the COBRA notice to the employees.

CHAPTER 4 – OTHER ELIGIBLE INDIVIDUALS FOR THE SEHP

I. OTHER ELIGIBLE INDIVIDUALS INFORMATION

A. In addition to covering themselves, a primary member can also elect coverage for other eligible individuals. These eligible individuals include:

1) A lawful wife or husband, referred to as "spouse" throughout the rest of this manual (Same gender marriages are not recognized under Kansas Law).
2) Any of the member's eligible dependent child(ren) also referred to as "dependent(s)" throughout the rest of this manual.

NOTE: If a primary member divorces, coverage for their former spouse and stepchild(ren) ends on the last day of the month of the date of the divorce. If the date of the divorce is the first day of the month, coverage for the member's former spouse and stepchild(ren) ends on the first day of that month.

B. An individual who is eligible to enroll as a primary member in the SEHP is not eligible to be enrolled as spouse or dependent of a primary member in the SEHP.

C. An eligible dependent that is enrolled by one primary member is not eligible to be enrolled as a dependent by another primary member.

D. "Other eligible individual" excludes any individual who is not a citizen or national of the United States, unless the individual is a resident of the United States or a country contiguous to the United States, is a member of a primary member's household, and resides with the primary member for more than six months of the calendar year. The dependent shall be considered to reside with the primary member even when the dependent is temporarily absent due to special circumstances, including illness, education, business, vacation, and military service.

E. "Permanent and total disability" means that an individual is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months. An individual shall not be considered to have permanent and total disability unless the individual furnishes proof of the permanent and total disability in the form and manner, and at the times, the SEHP may require.

F. The word "child" means:

1) A natural son or daughter of the primary member
2) A lawfully adopted son or daughter of the primary member. Lawfully adopted will include those instances in which a primary member has filed a petition for adoption with the court, has a placement agreement for adoption or has been granted legal custody. Please see **Section III. A.** below for supporting documentation requirements.
3) A stepchild of a primary member. If the natural or adoptive parent of the stepchild is divorced from the primary member, the child no longer qualifies as the primary member's stepchild, and is no longer eligible for coverage.

4) A child of whom the primary member has legal custody. Legal custody ends once the child reaches the age of 18.
5) A grandchild, if at least one of the following conditions is met:
   I. The primary member has legal custody of the grandchild or has lawfully adopted the grandchild
   II. The grandchild lives in the home of the primary member and is the child of a covered eligible dependent child and the primary member provides more than 50% of the support of the grandchild; or
   III. The grandchild is the child of a covered eligible dependent child and is considered to reside with the primary member even when the grandchild or eligible dependent child is temporarily absent due to special circumstances including education of the covered eligible dependent child, and the primary member provides more than 50% of the support for the grandchild.

A Dependent Grandchild affidavit (see **Appendix K**) must be completed and submitted along with a copy of the grandchild's birth certificate.

G. Eligible dependent child(ren) or stepchild(ren). To be covered under the SEHP, the child or stepchild must be less than 26 years of age.

H. Eligible dependent child(ren) or stepchild(ren) aged 26 or older who have a permanent and total disability as described in Section E above and has continuously maintained group coverage as an eligible dependent of the primary member before reaching the limiting age to be covered under the plan. The child must be chiefly dependent on the primary member for support (receive more than 50% of his or her support and maintenance from the primary member.)

An Application for Coverage of Permanent and Totally Disabled Dependent Child (see **Appendix L**) must be completed and submitted to SEHP Membership Services. If approved for continued coverage, medical documentation may be periodically requested. Coverage will not be continued and will not be reinstated once the dependent child is no longer considered permanent and totally disabled.

II. OTHER ELIGIBLE INDIVIDUAL'S EFFECTIVE DATE OF COVERAGE

Other eligible individuals shall become newly eligible on the later of:

A. The primary member's initial date of eligibility; or

B. The first day of the month following the date the individual first becomes an eligible individual of the primary member or becomes newly eligible for coverage according to the spouse or dependent definition. The newly eligible spouse or dependent must be added to coverage within 31 days of the date the primary member gains the new spouse or dependent or within 31 days of the date the spouse or dependent becomes newly eligible according to the spouse or dependent definition. The SEHP Membership Services must receive the Change Form and supporting documentation within 10 days of the date the Change Form is signed by the primary member.

C. The first day of the month following the loss of Medicaid or State Children's Health Insurance Program (SCHIP) coverage. The newly eligible spouse or dependent must be added to coverage within 60 days of the date of the loss of Medicaid or SCHIP coverage. The SEHP must receive the Change Form and any supporting documentation within 10 days of the date the Change Form is signed by the member.

III. PROCESSING NEWLY ELIGIBLE SPOUSE OR DEPENDENTS

All Enrollment or Change Forms adding newly eligible spouse or dependents must be completed and signed by the primary member within 31 days of the event that makes the spouse or dependent newly eligible. SEHP Membership Services must receive the form within 10 days of the date of signature. Coverage for the newly eligible spouse or dependents may be added if the primary member is enrolled in the SEHP on a pre-tax or an after-tax basis.

The change in coverage must be consistent with the event and/or must comply with HIPAA (Health Insurance Portability and Accountability Act) regulations.

Supporting documentation is required (see list below of appropriate documentation) as proof of the qualifying event. Requests that are submitted without documentation or with incomplete documentation will be returned to the Non State Employer Human Resources Representative via secure email with no action taken by the SEHP. The deadline for submitting the forms will not be extended.

In order to match spouse or dependent documentation to the appropriate member, the Non State Employer Human Resources Representative must verify prior to sending the documentation to the SEHP, that the primary member's name, employee ID, and the Non State Employer's group number is clearly written on top of each document.

A. Appropriate Supporting Documentation

The following items are appropriate supporting documentation required to be submitted to the SEHP with the Enrollment or Change Form when adding or removing other eligible individuals:

1. Marriage License in English (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement in English for newborns
3. Petition for adoption or placement agreement in English for dependent child
4. Legal custody or guardianship document issued by the court
5. Court order for dependents who are not natural or adopted children of the member
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild) (see **Appendix K**)
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older (see **Appendix L**).
8. Copies of the most current year's filed Federal tax return **(for proof of spouse eligibility only.)** The pages needed from the current filed Federal tax returns depend on which Tax form was filed:
    - Form 1040—pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
    - Form 1040A-- pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
9. Divorce decree in English (first and last page only of court document)
10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.

B. Newborns or Adoptions

1. To add a newborn dependent to coverage, the member **must** complete a Change Form adding the dependent to coverage within 31 days from the date of birth. SEHP Membership Services must receive the form within 10 days of the date of signature. For grandchildren, a copy of the birth certificate and a completed Dependent Grandchild Affidavit (see **Appendix K**) must be attached to the Change Form. No coverage will be provided for the newborn child until SEHP Membership Services has processed the Change Form and appropriate documentation**.**

A signed change form **must be submitted** to SEHP Membership Services within 31 days of the date of the newborn's birth to add them to the SEHP benefits. If the signed change form is not received, coverage for the newborn will automatically be provided based upon the following enrollment of the primary member's SEHP benefits:

- If the primary member already has children or family coverage, the newly eligible dependent will be covered starting with the date of birth through the 31st day. Coverage for the newborn ends on the 32nd day. If the child is successfully added within the first 31 days of the newborn's birth, continuous coverage will be provided for the newborn.

- If the primary member already has spouse coverage, the newly eligible dependent will be covered for only the first 31 days from the date of birth. Coverage for the newborn ends on the 32nd day. If the child is successfully added within the first 31 days of the newborn's birth, a coverage level change to Employee and family and an appropriate premium change will occur the first of the month following the date of birth of the newborn.

- If the primary member has single coverage, the newly eligible dependent will be covered for only the first 31 days from the date of birth. Coverage for the newborn ends on the 32nd day. If the child is successfully added within the first 31 days of the newborn's birth, an appropriate change in coverage level and premium will occur the first of the month following the date of birth of the newborn.

  NOTE: Regarding a newborn child of a dependent child (grandchild); the grandchild will only be covered for the first 5 days from the date of birth. Coverage for the grandchild will end on the 6th day if the primary member does NOT complete a Change Form requesting to add the dependent grandchild to coverage (along with appropriate supporting documentation) within 31 days from the date of birth. SEHP Membership Services must receive the form within 10 days of the date of signature.

2. In the case of adoption, the dependent must be added to coverage within 31 days of the date that the petition for adoption or placement notice is filed or the date of adoption placement. A copy of the petition for adoption or placement notice must be attached to the Change Form. SEHP Membership Services must receive the form and documentation within 10 days of the date of signature.

   If the adoption is being handled through an adoption agency, they may require an adjustment period in the primary member's home prior to filing the petition for adoption. In this case, a copy of the adoption agency's placement letter must be attached to the Change Form and must indicate the date of placement as well as the length of the adjustment period.

   When the adjustment period is over and the petition for adoption has been filed with the court, the primary member must submit a copy of the petition for adoption in order to continue coverage for the dependent. If the dependent is removed from the primary member's home, or the petition for adoption is not filed, a Change Form must be submitted to remove the dependent from coverage.

   The Non State Employer Human Resources Representative should contact SEHP Membership Services for guidance if the dependent is being adopted and a petition for adoption is never filed in a U.S. court (which is sometimes the case with foreign adoptions).

C. Effective Date of Coverage

If the date of the filing for petition for adoption or placement in the home is within 31 days of the birth of the child, the coverage effective date is the date of birth provided the SEHP Membership Services receives documentation within 41 days of the birth of the child. If the filing placement is not within 31 days of the date of birth of the child, the effective date of coverage is the date of the filing date of the petition for adoption **or** the date of placement, whichever the case may be. The effective date of coverage cannot be earlier than the child's placement or arrival in the primary member's home within the United States.

If adding a newly eligible newborn or adopted dependent to coverage, other eligible dependents may also be added to coverage. The effective date of coverage for the newborn or adopted dependents will be the date of birth if a Change Form is completed within 31 days of the applicable child's birth. SEHP Membership Services must receive the form and documentation within 10 days of the date of signature. The effective date of coverage for other eligible dependents, such as spouse and/or other children or stepchildren of the primary member, will be the first day of the month following the birth, date of placement for adoption or date of petition for adoption.

D. Change in Employee Contribution

The change in coverage will be reflected in the employee's contribution beginning the first of the month following the date of birth, date of petition for adoption or date of the placement agreement. If the date of birth, date of petition for adoption, or date of the placement agreement occurs on the first day of the month, the change in employee contribution shall not take place until the first of the following month.

E. New Legal Custody/Guardianship Dependents (for dependents who are not natural or adopted children of the member)

If the primary member is adding a newly eligible legal custody/guardianship dependent to coverage, the primary member **must** complete a Change Form to add the dependent to coverage within 31 days of the date that the court issues a legal custody agreement. SEHP Membership Services must receive the Change Form within 10 days of the date the Change Form is signed. A copy of the court order or legal custody agreement must be attached to the Change Form.

The effective date of coverage will be the first day of the month following the date of legal custody or guardianship. If the date of legal custody or guardianship occurs on the first day of a month, the coverage effective date will be the first day of the month.

Employee contributions will be due according to the dependent coverage effective date.

F. New Spouse or Stepchildren Due to Marriage

If the primary member wants to add a new spouse and/or stepchild(ren) to coverage due to marriage, the primary member **must** complete a Change Form adding the spouse and/or dependents to coverage within 31 days of the event (marriage). SEHP Membership Services must receive the appropriate Change Form along with appropriate supporting documentation within 10 days of the date the Change Form is signed.

The effective date of coverage will be the first day of the month following the date of marriage. If the marriage occurs on the first day of the month, the coverage effective date will be the first day of that month.

If adding a newly eligible spouse or stepchild(ren) to coverage, other eligible dependents may also be added to coverage, such as other children of the primary member. The effective date of coverage for these dependents will be the first day of the month following

the date of marriage. Employee contributions will be due according to the dependent coverage effective date.

If the employee has previously waived coverage, and acquires a newly eligible spouse or dependent, (marriage, birth, adoption, etc.) the employee must complete a new Enrollment Form and submit it to the SEHP along with the appropriate documentation within 31 days of the date of the event. Coverage for the employee and newly eligible spouse and dependent(s) will be effective the first of the month following the date of the qualifying event. In the case of a newborn, coverage for the newborn will be the date of birth, but coverage for the employee will be the first of the month preceding the newborn's date of birth. Any spouse or other dependents added during this qualifying event will be effective the first of the month following the date of birth of the newborn.

IV. ADDITIONAL INFORMATION

A. Children of divorced parents - A primary member may cover their dependent children:

1) Who are under the age 26, or
2) Who have a permanent and total disability and have continuously maintained group coverage as an eligible dependent of the primary member before reaching the limiting age to be covered under the plan. The child must be chiefly dependent on the primary member for support (receive more than 50% of his or her support from the primary member).

B. Ex-Spouse - When the member is divorced from their lawful wife or husband, the ex-spouse and subsequent stepchildren are no longer eligible to participate in the SEHP except as allowed under COBRA continuation coverage.

C. Spouses residing out-of-country

A spouse (of an eligible primary member) who is not a U.S. citizen and resides in another country, is eligible for SEHP coverage when the primary member is newly eligible, when newly married to the primary member, when they move and maintain a permanent United States residence, including having an active U.S. Social Security or Tax Identification Number from the U.S. government or at Open Enrollment. The primary member will be allowed to add the spouse to coverage provided the request is made by the primary member within 31 days of any of these events. If the spouse later returns to another country, coverage may not be dropped for the spouse until the next Open Enrollment period (unless enrolled on an after-tax basis). Documentation is required to support the member's request.

D. Dependents residing out-of-country

A dependent child(ren) (of an eligible primary member) who is not a U.S. citizen and resides in another country, is eligible for SEHP coverage when the primary member is newly eligible, when they move and maintain a permanent United States residence, including having an active U.S. Social Security or Tax Identification Number from the U.S. government or at Open Enrollment. The primary member will be allowed to add the dependent child(ren) to coverage provided the request is made by the primary member within 31 days of any of these events. If the child(ren) later returns to another country,

coverage may not be dropped for the child(ren) until the next Open Enrollment period (unless enrolled on an after-tax basis). Documentation is required to support the member's request.

E. Adopted child

A member may cover an adopted child if the petition for adoption has been filed with the court, if the member has a placement agreement for adoption, or if the member has been granted legal custody of the child. Supporting documentation must be provided in English and must be submitted to SEHP Membership Services. Adopted children who are not U.S. citizens and who reside in another country are not eligible for coverage until they move and maintain a permanent United States residence. If the child(ren) later returns to another country, coverage may not be dropped for the child(ren) until the next Open Enrollment period (unless enrolled on an after-tax basis).

F. Special Notes

1) The State of Kansas and the SEHP reserve the right to request documentation to support proof of dependency and/or residency. When enrolling other eligible individuals for coverage with the SEHP, the member must certify:
   i. The spouse and/or dependent(s) meet the requirements for other eligible individuals for the year in which the spouse and/or dependent(s) are being enrolled.

   ii. The member must also provide appropriate supporting documentation for their spouse and each dependent (such as the birth certificate, adoption papers, marriage license, etc.) See additional information above in **Section III A.**

2) In order to match other eligible individual documentation to the appropriate member, the Non State Employer Human Resources Representative must verify prior to sending the documentation to SEHP Membership Services, that the member's name, employee ID, and the Non State Employer group number is clearly written on top of each document

3) Requests that are submitted without documentation or with incomplete documentation will be returned to the Non State Human Resources Representative with no action taken by the SEHP. The deadline for submitting the forms will not be extended.

ANY ATTEMPT TO ENROLL OTHER ELIGIBLE INDIVIDUALS WHO DO NOT MEET THE SEHP REQUIREMENTS WILL BE CONSIDERED FRAUD AND WILL BE SUBJECT TO PENALTIES AS PRESCRIBED BY LAW.

CHAPTER 5 - EMPLOYEE MEDICARE ELIGIBILITY

Congress has created a framework in the Medicare statutes and the Internal Revenue Code that imposes responsibility on an employer for its plan's actions in certain circumstances. The Medicare Secondary Payer (MSP) provisions of the Social Security Act (42 U.S.C. 1395y(b)) state that Medicare may seek to recover a mistaken primary payment from "any entity which is required or responsible" to pay for medical services under a primary plan. Accordingly, Medicare may seek recovery from the employer.

The MSP provisions generally require group health plans to make payments primary to Medicare for: (1) individuals entitled to Medicare on the basis of age or disability if the individual has coverage under the group health plan on the basis of the individual's own or a family member's current employment status; and (2) individuals who are or could be entitled to Medicare on the basis of end stage renal disease for a 30 month coordination period if the individual is covered under a group health plan, as defined in the Internal Revenue Code, on any basis. Taken together, the MSP provisions and the definition of group health plan establish that employers have, or at least share, responsibility for the group health plan's compliance with the MSP rules.

For this reason it is very important to ensure that our members, their spouses and dependents are accurately enrolled in the Health Plan. The SEHP must be aware of any Medicare eligibility and entitlement so that the SEHP can communicate this information to our carriers. If a Non State Employer receives a demand letter from a Medicare secondary payer recovery contractor, forward the letter and any attached documentation to SEHP Membership Services.

I. EMPLOYEES AND SPOUSES WHO ARE APPROACHING AGE 65

When an active Non State employee or covered spouse turns age 65, they must complete a TEFRA (Tax Equity & Fiscal Responsibility Act of 1982) Health Care Selection Form (see **Appendix D**). On the TEFRA form, the Non State employee or covered spouse must select Medicare or the SEHP as primary carrier. SEHP Membership Services will send a list to each Non State Employer Human Resources Representative of impacted employees or covered spouses approximately 60 days prior to the employee's or spouse's 65th birthday advising them that a TEFRA Form must be completed by the employee or spouse. The Non State Employer Human Resources Representative should contact the employee and/or covered spouse and obtain a signed TEFRA form from them. (Please see **Appendix D-1** for a sample letter that can be used to contact the employee and **Appendix D-2** that can be used to contact the spouse.) The TEFRA Form must be completed 30 days prior to the 65th birthday of the employee or covered spouse and received by SEHP Membership Services within 10 days of completion. If the employee or spouse has a Medicare card, a copy should be attached to the TEFRA form.

A. If the employee / spouse selects the State Employee Health Plan as primary:

The employee / spouse may continue the same coverage at the same rate with the SEHP. Claims for the member and spouse will be processed with the SEHP as primary.

B. If the employee selects Medicare as primary:

1. If Medicare is selected as primary, the employee will be removed from the SEHP medical and dental benefits effective the 1st of the month in which they become eligible

for Medicare. If the employee turns age 65 on the first day of the month, Medicare eligibility will begin the first day of the previous month, the SEHP benefits will terminate on that day. Coverage for all dependents will also be terminated as of the same date. The TEFRA form will be used to terminate the medical and dental benefits. Vision coverage is not affected by Medicare, so if the member and any dependents are enrolled in the vision coverage, the vision coverage will not be terminated.

If the spouse selects Medicare as primary, the spouse will be removed from the SEHP benefits effective the 1st of the month in which they become eligible for Medicare. The TEFRA form will be used to terminate the medical and dental benefits. Vision coverage is not affected by Medicare, so if the spouse is enrolled in the vision coverage, that coverage will not be terminated.

2. The covered spouse and/or dependent children can continue coverage on COBRA for up to 36 months or until entitled to Medicare, whichever occurs first.

II. EMPLOYEES, SPOUSES AND DEPENDENTS WITH MEDICARE DUE TO DISABILITY

New hires should be asked if they or any dependents that they plan to cover under the SEHP are Medicare eligible. Medicare information should be completed on the Enrollment Form and a copy of the Medicare card should be attached to the form.

Active employees, spouses and/or dependents that become newly eligible for Medicare due to disability during the plan year have the option to continue to participate in the SEHP or to have Medicare coverage as primary. A Change Form indicating "Other – Medicare eligibility" should be completed to report Medicare information and a copy of the Medicare card should be attached. Those who want Medicare as primary must be terminated from the SEHP on the Change Form. The member will be removed effective the first day of the month that Medicare becomes effective.

Federal law mandates Medicare to be the secondary payer of claims for active employees or their dependents that choose to remain covered by the SEHP, even though they are disabled and entitled to Medicare benefits.

III. EMPLOYEES, SPOUSES AND DEPENDENTS WITH MEDICARE DUE TO END STAGE RENAL DISEASE (ESRD)

Persons with ESRD may be eligible for Medicare primary coverage for a period of time as determined by Federal guidelines. The ESRD Questionnaire (**Appendix J**) should be completed and forwarded to SEHP Membership Services immediately when ESRD is diagnosed for a covered member, spouse or dependent, so that appropriate Medicare eligibility information can be forwarded to the medical plans and members.

When Medicare is primary for a covered person with ESRD, there is no change in active employee rates, coverage eligibility or benefits. However, medical claims are processed with Medicare coverage as primary and SEHP coverage as secondary.

CHAPTER 6 - COST OF COVERAGE

Employee and Non State Employer Group contributions for the SEHP are subject to change each Plan Year. SEHP coverage is monthly and rates are based on monthly periods. Coverage termination will be effective the first day of the month following termination of employment.

I. EMPLOYEE RATES

SEHP employee rates are based on the following criteria:

A. Full-time or part-time employment status of the employee's position (see Chapter 3, Section VI)

1. For full-time employees, the Non State Employer is required to contribute approximately 95% of the cost of single coverage and approximately 55% of the additional cost for dependent coverage. The Non State Employer may choose to pay more than the required amount for employee and dependent coverage.

2. For part-time employees, the Non State Employer is required to contribute approximately 75% of the amount contributed for full-time employees.

B. Annual salary range (Plan Year 2011) of the employee's position (see Chapter 3, Section VII).

Salary Range 1:	annual salary less than $28,000
Salary Range 2:	annual salary of $28,000 to less than $48,000
Salary Range 3:	annual salary of $48,000 or more

Salary tiers must be reported for all employees on the Enrollment Form for coverage and salary tier changes must be reported to the SEHP each year in November. If the employer is paying 100% of the single employee premium, the salary tiers do not apply to the premiums however; the tiers must still be reported to the SHEP and updated annually.

C. Health (medical/prescription drug, dental and vision) plans selected

D. Tobacco Use Status

E. Coverage level selected

CHAPTER 7 - OPEN ENROLLMENT

I. ANNUAL OPEN ENROLLMENT PERIOD

Open Enrollment for health benefits occurs annually during the month of October. A member who enrolls during the Open Enrollment period will have coverage effective the first day of the new Plan Year as outlined in the current Health Plan Summary/Open Enrollment booklet.

Non State Employer Group eligible members must complete the Open Enrollment process by completing an Open Enrollment Form during the month of October each year. During this period , eligible members must disclose their Tobacco Use status each year, can change medical plans, add or drop coverage, add or drop a spouse or dependent from coverage, or change pre-tax payment status (if offered by the Non State Employer Group).

Eligible employees who are on Leave Without Pay or Family Medical Leave Act must be sent Open Enrollment materials by the Non State Employer Human Resources Representative to be completed and submitted during the Open Enrollment period.

Members can also provide change of address notification on the open enrollment form. This ensures that current addresses are maintained by the SEHP so that employees can receive health plan information timely.

Members can change their Health Savings Account (HSA) contribution amount if enrolled in the Qualified High Deductible Health Plan.

Non State Employer Human Resources Representatives should review each Open Enrollment Form for completeness and accuracy before sending the forms to SEHP Membership Services. Incomplete Open Enrollment Forms will be returned to the Non State Employer for correction. Corrected forms must be returned within fourteen (14) days of receipt or by the deadline for submitting all Open Enrollment Forms, whichever is later.

Supporting documentation is required (See **Chapter 4, Section III. A** for the list of appropriate documentation) as proof of dependent eligibility. Open Enrollment Forms submitted without documentation or with incomplete documentation will be returned to the Non State Employer Human Resources Representative with no action taken by the SEHP. The deadline for submitting the forms will not be extended.

In order to match spouse or dependent documentation to the appropriate member, the Non State Employer Human Resources Representative must verify prior to sending the documentation to the SEHP, that the primary member's name, employee ID, and the Non State Employer's group number is clearly written on top of each document.

II. PRE-EXISTING CONDITIONS

The SEHP does not apply an additional waiting period for pre-existing conditions for members, their spouses and their dependents that enroll in health coverage during the Open Enrollment period. Certificates of Creditable Coverage from other medical plans are not needed for Open Enrollment.

III. NEWLY ELIGIBLE MEMBERS

Newly eligible members who have completed their 30 day waiting period may enroll during their initial enrollment period for an effective date of coverage for the current Plan Year. In addition, during the month of October, the member may complete Open Enrollment and elect different coverage to be effective for the new Plan Year. **Open Enrollment must be completed for each eligible employee in order to be eligible for the non tobacco use premium discount each plan year.**

IV. REVISED OPEN ENROLLMENT ELECTIONS

A member may change their original Open Enrollment election during the Open Enrollment period. However, following the end of the Open Enrollment period, revised Enrollment Forms will only be accepted if the member has a qualifying event or family status change as listed in **Chapter 11**. The revised Enrollment Form must be completed within 31 days of the qualifying event or family status change and received by SEHP Membership Services within 10 days of completion. Dependent documentation (see **Chapter 4, Section III. A** for the list of appropriate documentation) must accompany the Enrollment Form. Requests that are submitted without documentation or with incomplete documentation will be returned to the Non State Employer with no action taken by the SEHP. The deadline for submitting the forms with documentation will not be extended.

V. OPEN ENROLLMENT CONFIRMATION STATEMENTS

The SEHP will send Open Enrollment confirmation statements to the Non State Employer in mid to late December for distribution to their employees. The Non State Employer should ask their employees to review their confirmation statements and report any discrepancies to their Non State Employer Human Resources Representative immediately. If discrepancies are not reported within 15 business days of the date of the confirmation statement, enrollment corrections and/or adjustments will not be made.

VI. IDENTIFICATION CARDS

Identification (ID) cards will be sent to new members and members making coverage level changes. If a member is expecting but does not receive a new ID card by the end of December, the member should contact the applicable carrier to request new ID cards be sent. Telephone numbers for the carriers are listed in the front of the SEHP/Open Enrollment booklet and can be found on the SEHP web site at:

http://www.sehbp.org/providers/active-state-and-non-state-group

CHAPTER 8 - HEALTH PLAN MATERIALS

I. BENEFIT DESCRIPTIONS / CERTIFICATES / BOOKLETS

SEHP carriers will mail Benefit Descriptions for self insured plans and Certificates of Coverage for fully insured plans to all enrolled members directly to their last known home address. Certificate books will be sent after SEHP Membership Services has processed the member's Enrollment Form and the carrier has processed the member's information. The Certificate of Coverage and Benefit Description are also available on the website at:
http://www.sehbp.org/choose

II. IDENTIFICATION CARDS

Separate Identification (ID) Cards are issued by the appropriate carrier for medical, prescription drug and dental coverage. Members electing vision coverage will also receive an ID card. Dental and vision ID cards may also be obtained by accessing the carrier's web site. Members should allow 2 to 3 weeks after the date the Enrollment Form has been received by SEHP Membership Services for coverage to be established with the applicable carrier(s).

SEHP carriers will mail Identification Cards directly to the member's last known home address. If a member has not received an ID card after 3 weeks, the member should contact their carrier and request that a new card be sent. Members should carry their ID cards at all times and present the appropriate ID card whenever covered services or benefits are needed.

For additional information concerning identification cards and Open Enrollment, refer to **Chapter 7, Section VI** in this manual.

III. PROVIDER LISTINGS

The most current provider lists are available on each carrier's website. This information can be accessed through the SEHP website at:
http://www.sehbp.org/providers/active-state-and-non-state-group

Members may call their carriers using a local or toll free number (depending on the member's location) as listed on the ID card or on the SEHP web site. Addresses for medical carriers are also listed in **Appendix O.**

REMINDER: Non State Employer Human Resources Representatives must ensure that current valid employee addresses are on file with SEHP Membership Services. It is important that current addresses are maintained by the SEHP so that employees can receive health plan information timely.

CHAPTER 9 - ENROLLMENT FORM AND INSTRUCTIONS

I. ENROLLMENT FORM

The Enrollment Form (see **Appendix B**) is to be used as an application for new coverage and as an authorization by the eligible employee for the Non State Employer to deduct the employee's contributions from the employee's paycheck for the coverage selected. **Employees, covered spouses and dependents must be enrolled in the same medical plan.**

The Enrollment Form must be completely filled out according to the type of coverage selected. All information is required in order to set up the status records of each eligible employee. The Enrollment Form must be completed and signed by the employee within 31 days of new eligibility by becoming employed in a benefits eligible position. The completed and signed (by both the employee and the Non State Employer Human Resources Representative) Enrollment Form with the appropriate documentation must be received by SEHP Membership Services within 10 days of the employee's signature. Enrollment Forms that are submitted without supporting documentation or with incomplete supporting documentation (please see **Chapter 4**) will be returned to the Non State Employer with no action taken by the SEHP. The deadline for submitting the forms with documentation will not be extended.

For any situation that an employee is not required to meet the 30 day waiting period requirement, an explanation should be written on the Enrollment Form. The employee's contribution must initially be paid on an after-tax basis when the 30 day requirement is waived. The member may change to the pre-tax premium option effective the first day of the month that their coverage would have become effective without the waiver. If the member desires to change to the pre-tax option after this time period, a Change Form must be submitted along with a copy of the original Enrollment Form to SEHP Membership Services. Both forms must be signed by the member. A copy of the waiver approval letter must be attached to the Enrollment Form. For example:

- Waiver of the 30 day waiting period—attach a copy of the approval letter from the SEHP to the form.
- Employee changing from non-eligible to eligible status
- Return from leave for an employee who did not continue under Direct Bill
- Employee has terminated, had health insurance and was not gone from Non State employment more than 30 days
- Employee was laid off from Non State employment and is returning to a benefits eligible position within 1 year from the date of layoff

For all of the above events, eligibility dates, dates of return from leave, and any other appropriate event dates must be indicated on the Enrollment Form.

Upon completion, the employee should return the Enrollment Form and all required documentation to their Non State Employer Human Resources Office. The completed and signed Enrollment Form should be reviewed by the Non State Employer Human Resources Representative to ensure that all required information including dependent documentation is supplied. The Non State Employer Human Resources Representative should then forward the completed Enrollment Form to the following address:

(Continued on next page)

State Employee Health Plan
Membership Services
Room 900 – Landon State Office Building
900 SW Jackson Street
Topeka, Kansas 66612-1220
Fax Number: 785-368-7180

SEHP Membership Services must receive the completed and signed Enrollment Form and the appropriate documentation within 10 days of completion. If approved, SEHP Membership Services staff will enter the information from the form into their membership system. Enrollment information will then be forwarded to the appropriate carrier(s). Allow 2 to 3 weeks after the Enrollment Form is received by SEHP Membership Services for coverage to be established with the applicable carrier(s).

For questions regarding completion of the Enrollment Form, the Non State Employer should call SEHP Membership Services at (785) 296-3226.

II. INSTRUCTIONS FOR COMPLETION

A. For HR Use Only (to be completed by the Non State Employer Human Resources Representative)

Enter the appropriate information to indicate:

- The Effective Date of the employee's coverage (required)
- The Employee ID number (required)
- The State Agency Number (not applicable if Non State Employer Group)
- The Non State Group Number (required)

B. Employee Information (to be completed by the employee or retiree)

This section includes information supplied by the employee and includes:

- The employee's name (required)
- Mailing address (required - enter address correction if needed)
- Contact telephone number (required)
- Social Security Number (required)
- Gender (required)
- Date of birth (required)

C. Tobacco Use

Tobacco use – the employee must indicate whether or not they:

- Use tobacco;
- Do not use tobacco, or
- Whether they choose not to disclose use/non-use.
- Declare willingness to enroll in the tobacco cessation program

Before making their selection, the member should read and understand the information on the back of the Enrollment Form. The bubble that is darkened allows the member to claim or to not claim the non-tobacco use premium discount. **If no bubble is darkened (this includes not completing the question regarding willingness to enroll in and complete the cessation program), the default selection does not allow the member to claim the non-tobacco use discount. Forms are not returned for incomplete or missing Tobacco Use information.**

D. Type of Action (to be completed by the Non State Employer Human Resources Representative)

Darken the appropriate bubble to indicate:

- Open Enrollment
- New address (see above)
- New Employee
- Other. When 'Other' is checked, refer to **Chapters 4 or 11**. Supporting documentation for the event must be included with the Enrollment Form. Enrollment Forms submitted without the appropriate supporting documentation will be returned to the NSE with no action taken by the SEHP. The deadline for submitting the Forms will not be extended
- Date of Event

E. Employee Information (to be completed by the Non State Employer Human Resources Representative)

Required information includes:

- The date the employee was currently employed in an eligible position
- The date the employee was employed in a non-eligible position (if applicable)
- Whether or not the employee is currently enrolled as a dependent in the SEHP
- Choice of Benefit Program Group for Non State Employers

Coverage Election (to be completed by the employee or retiree)

The employee or retiree must indicate whether they want to pay for the cost of coverage:

- Before tax, or
- After tax

F. Medical Insurance Provider (to be completed by the member)

Members may choose from any currently offered medical plan. Members may also choose to waive medical/dental/prescription drug coverage. Members who enroll in the Qualified High Deductible Health Plan (Plan C) must also enroll in the Health Savings Account associated with the carrier and the corresponding bank listed below (see **Chapter 21**).

The member must complete an enrollment application for the appropriate HSA bank. The enrollment applications may be found on the SEHP website at:

http://www.sehbp.org/state-employee-health-plan-home--2/choosing-your-health-plan/plan-c-qhdhp-with-hsa/plan-c-contribution-and-banking-information **(Continued on next page)**

Plan Name	QHDHP Bank	Web Site
Coventry Health Care of Kansas	UMB Bank	https://hsa.umb.com/index.html
Preferred Health Systems*	Health Equity	www.HealthEquity.com
UMR – a United HealthCare Company	American Chartered Bank	www.AmericanChartered.com

The member should indicate their choice of health plans and their choice of carrier. Members use this section to select whether they want to enroll in Health Savings Accounts (HSA). The member that selects Plan A, B, or C, should darken only 1 bubble for the Medical Insurance Provider and Plan they choose.

NOTE: The Non State Employer will be responsible for establishing a relationship with the corresponding HSA banks and remitting both employer and employees' contributions to them

NOTE: Members who select Plan C with Preferred Health Systems will have their HSA automatically set up with Health Equity.

Medical Insurance Provider and Plan choices are:

- Blue Cross Blue Shield (Plan A and Plan B),
- Coventry Health Care of Kansas (Plan A, Plan B and Plan C - Qualified High Deductible Health Plan with Health Savings Account),
- Preferred Health Systems (Plan A, Plan B and Plan C - Qualified High Deductible Health Plan with Health Savings Account)
- UMR, A UnitedHealthcare Company(Plan A, Plan B and Plan C-Qualified High Deductible Health Plan with Health Savings Account)

NOTE: Members are not permitted to change Plans during the Plan Year. The only mid-year changes allowed are coverage level changes which are consistent with the qualifying event.

All members, spouses and dependents with medical coverage will also have the same level of prescription drug coverage. Members may elect one of the following coverage levels for medical and prescription drug. Prescription drug coverage through Caremark is provided for members that select a medical insurance provider and Plan. Members may select Medical and Prescription Drug Coverage levels by darkening a bubble to indicate what they elect:

- Waive coverage
- Coverage for Member only
- Coverage for Member and Spouse only
- Coverage for Member and Child(ren) only

- Coverage for Member and Family (Spouse and Child(ren))

Member only dental coverage is provided for all members enrolled in medical/prescription drug coverage. An employee may enroll in dental coverage only if they enroll in medical/prescription drug coverage. Employees may choose from among the following dental coverage levels by darkening the bubble for:

- Coverage for Member only
- Coverage for Member and all Dependents who are also enrolled in Medical coverage

NOTE: Dental only coverage is **NOT** available for dependents.

NOTE: Under SEHP guidelines, the enrollment for dependents in the medical and dental coverage must match. A member who currently has Employee/Spouse medical/dental and wants to add a dependent to the medical must also enroll the dependent in dental coverage, so that the dependent medical and dental coverage matches.

NOTE: Dependent dental coverage may not be dropped during the Plan Year unless dependent medical coverage is also dropped.

G. Vision Coverage Level (Optional)

Members may elect:

- The Basic Plan
- The Enhanced Plan
- Waive Vision Coverage

Members may elect a vision level different than their coverage level in a medical or dental insurance plan. **The dependent children covered in the vision plan must match/include the dependent children covered under the medical/prescription drug plan.** Members may choose from among the following coverage levels:

1. Member Only
2. Member and Spouse
3. Member and Child(ren)
4. Member and Family - with Spouse and Child(ren)

Vision coverage may be added during the Plan Year only for newly eligible employees, spouses and / or dependents. Members cannot change from Basic to Enhanced vision coverage or vice versa during the Plan Year.

Members may only enroll in the vision plan when first newly eligible (upon hire), or during Open Enrollment. Spouses and / or dependents may be added mid-year if a qualifying event makes them newly eligible (marriage, birth of child, etc.), and only if the Member is currently enrolled in a vision plan. Members, who initially waived vision coverage and have a mid-year qualifying event acquiring a spouse or dependent, will not be allowed to enroll themselves, their spouse or dependent(s) in the vision coverage. Please see **Chapter 11** for a list of qualifying events.

Newly eligible spouses and / or dependents may be added to vision coverage only if the member has elected vision coverage.

H. Dependent Information

For each member, spouse and covered dependent, the following information is required on the Enrollment Form. Relationship Codes can be found on the back of the form:

- Relationship Code (from the back of the form (e.g., child, spouse, stepchild, etc.) The Non State Employer Human Resources Representative shall collect and submit supporting documentation for each covered spouse and dependent. The SEHP and/or the carrier may request documentation to support proof of relationship or dependency;
- Full Name – last name, first name, middle initial;
- Social Security Number (SSN) is required for every individual over 60 days old. If the SSN is not received, an alternative number will be assigned by SEHP Membership Services and will be maintained until the employee sends the SSN to SEHP Membership Services;
- Gender (required);
- Date of Birth (required) – If the member or spouse is age 65, a TEFRA Health Care Selection Form (see **Appendix D**) must be completed. If Medicare is selected as primary coverage, the member or spouse must be removed from SEHP coverage (see **Chapter 5**);
- Dependent address. The member must provide the dependent's address if it's different from theirs.

NOTE: To be enrolled as a spouse or dependent under a member's coverage in the SEHP, the member, spouse and the dependent must be enrolled in the same medical plans.

NOTE: In order to match spouse or dependent documentation to the appropriate member, the Non State Employer Human Resources Representative, must verify prior to sending the documentation to the SEHP, that the member's name, employee ID, and the Non State Group Number is clearly written on top of each document.

NOTE: If the dependent's address is the same as the member's address, darken the appropriate bubble in this section. If the dependent's address is different than the member's, darken the appropriate bubble and provide the dependent's address.

NOTE: Non State Employer Human Resources Representatives must ensure that current valid employee addresses are on file with SEHP Membership Services. It is important that current addresses are maintained by the SEHP so that employees can receive health plan information timely.

I. Medicare

If the member, spouse, and/or dependent are eligible for Medicare and are to be covered under the SEHP, the member should complete this section and is required to attach copies of all Medicare cards.

- Name – last, first, middle initial;

- Hospital (Part A – month/day/year);
- Medical (Part B – month/day/year);
- Medicare Claim Number

J. Employee Authorization

In this section, the employee signs and dates the Enrollment Form. Non State Employer Human Resources Representative should make sure that the employee understands that by signing, the employee agrees to the terms and conditions that are written on the back of the form. The requirement for supporting documentation is described here. The SEHP will return unsigned forms to the Non State Employer and will not extend the deadline for completion.

K. Personnel Officer Authorization

In this section, Non State Employer Human Resources Representative signature, date, and phone number are required. Enrollment Forms without this information will be returned to the Non State Employer.

The Non State Employer Human Resources Representative must review Enrollment Forms prior to forwarding to SEHP Membership Services. Non State Employer Human Resources Representatives must ensure that the form is complete, signed, that supporting documentation is included, and that the employee agrees to the terms and conditions on the back of the form.

CHAPTER 10 - CHANGE FORM AND INSTRUCTIONS

I. CHANGE FORM AND INSTRUCTIONS

A **Change Form** (see **Appendix C**) must be filled out for all enrollment changes. Changes in coverage will not be made until the completed form is received by SEHP Membership Services. Crossing an employee off the monthly billing will not be accepted as fulfilling the Non State Employer Group's responsibility to notify SEHP Membership Services of a request for coverage changes. The Non State Employer will be responsible for all premiums that result from failure to provide changes in a timely manner and on the proper form.

Change Forms are required in the following situations:

- Marriage - adding newly eligible dependents
- Divorce - removing ineligible spouse and dependents
- Newborns - Adding a dependent due to the birth or adoption of a child
- A Spouse or dependent child's gain/loss of employment and benefits
- Termination of employment
- Mid-year enrollment changes (see **Chapter 11**)
- Name changes
- Address changes
- Personal data corrections (such as date of birth, SSN, etc.)
- Transfers between Non State Employer Groups:
  1) Change Form from prior group
  2) Enrollment Form from new group
- Cancellation of member due to non-payment of premiums
- Change from an eligible to non-eligible position or vice versa
- All retirements (whether enrolling in Direct Bill coverage or discontinuing SEHP coverage) (see **Chapter 17**)
- Members approved for disability and who wish to continue SEHP coverage (see **Chapter 17**)
- Leave Without Pay (see **Chapter 12**)
- Death of a member with or without dependent coverage (See **Chapters 11 & 17**)
- Adding Social Security numbers for children over 60 days old
- Termination of a member on leave of absence

NOTE: Change Forms are **not** required in the following situations:

- Dependents turning age 26 – SEHP Membership Services will notify the member and the NSE Human Resources Representative 60 days prior to the dependent's 26th birthday, when coverage terminates

Upon completion, the Change Form is to be returned by the member to the member's Non State Employer Human Resources Representative. The completed and signed Change Form should be reviewed by the Non State Employer Human Resources Representative to ensure all required information and appropriate supporting documentation is supplied. The form must be sent or faxed within 10 days of the member's signature to the following address:

State Employee Health Plan
Membership Services
Room 900 - 900 SW Jackson Street
Topeka, Kansas 66612-1220
Fax Number: 785-368-7180

It is the **member's responsibility** to keep their membership status current with the Non State Employer. Changes **will not be made** until the Change Form has been completed by the Non State Employer and received by SEHP Membership Services. Enrollment or Change forms submitted without the appropriate supporting documentation will be returned to the Non State Employer with no action taken by the SEHP. The deadline for submitting the Forms will not be extended.

Changes in coverage that are prescribed by law or contract (i.e., dependents losing coverage due to divorce at the end of the coverage period) will take effect retroactively to the last day of eligibility regardless of when a Change Form was completed. Adjustments must be made by the Non State Employer. Refunds should not be initiated if the employee failed to complete the Change Form within 31 days of the event.

It is the **Member's responsibility** to:

- notify their Non State Employer Human Resources Representative of changes concerning name, address, marital status, geographic relocation or other applicable personal life changes;
- ensure that Change Forms are complete, signed and dated, and that the appropriate supporting documentation is included with the form. The documentation must have the member's name, employee ID, and the Non State Group Number clearly and legibly written on the documentation

It is the **Non State Employer Human Resources Representative's responsibility** to:

- complete the Change Form for changes in eligibility, Leave Without Pay, or return from Leave Without Pay;
- ensure that the member has signed and dated the Change Form;
- ensure that the appropriate supporting documentation has been provided by the member, has the member's name, employee ID, and the Non State group number clearly and legibly written on top of each document, and is included with the Change Form;
- ensure that the Non State Employer Human Resources Representative has signed and dated the Change Form;
- ensure that all required fields on the form are completed prior to forwarding to SEHP Membership Services;
- forward the completed Change Forms and appropriate supporting documentation to SEHP Membership Services within 10 days of the date of the member's signature.

II. INSTRUCTIONS FOR COMPLETION

A. For HR Use Only (to be completed by the Non State Employer Human Resources Representative)

Enter the appropriate information to indicate:

- The Effective Date of the employee's coverage (required)
- The Employee ID number (required)
- The State Agency Number (not applicable if Non State Employer Group)
- The Non State Group Number (required)

B. Employee Information (to be completed by the employee or retiree)

This section includes information supplied by the employee and includes:

- The employee's name (required)
- Mailing address (required - enter address correction if needed)
- Contact telephone number (required)
- Social Security Number (required)
- Gender (required)
- Date of birth (required)

C. Enrollment Change (to be completed by the Employee).

This section is used to tell the SEHP what changes the member wants made to their SEHP coverage. All changes must be made within the appropriate SEHP guidelines. The employee should darken the appropriate bubble to indicate whether or not the member wants to:

1. Add / drop dependent medical;
2. Add / drop dependent dental, or
3. Add /drop dependent vision coverage.

The Non State Employer Human Resources Representative completes the next section, which includes Coverage Level Codes to indicate the member's change to:

1. Medical/Rx coverage levels;
2. Dental coverage level;
3. Vision coverage level, and
4. The date the qualifying event occurred that caused the need for the change.

Type of Event

The Non State Employer Human Resources Representative completes this section which indicates what the event is that is the basis for the member's request.

D. Dependent Information

Action – (To be completed by the employee or the retiree). The member uses this section to Add or Delete a Dependent from SEHP coverage.

1. Action – Add or Delete a Dependent – Darken the bubble that's appropriate for the member's requested action.

2. Relationship Code – Enter the appropriate code, obtained from the back of the Change Form

3. Name – Enter the dependent's name

4. Social Security Number (required) – Enter the dependent's Social Security Number

5. Gender (required) – Darken the bubble that's appropriate for the dependent's gender

6. Date of Birth (required) – Enter the dependent's date of birth in Month / Day / Year format

7. Dependent Address – Darken the bubble that's appropriate for the dependent's address. If the dependent's address is different from the member's address, please enter the dependent's address in the space.

E. Medicare

1. Name – include the name of the spouse or dependent in this space

2. Hospital (Part A) – include the date the spouse or dependent became eligible for Medicare Part A coverage

3. Medical (Part B) – include the date the spouse or dependent became eligible for Medicare Part B coverage

4. Medicare Claim Number – include the spouse or dependent's Medicare coverage ID number

F. Employee and Personnel Officer Authorization – Required

1. The member is required to sign and date this document. If the member is not available to sign the document (leave, cancellation due to lack of premiums, termination, hospitalization, death, etc.), the Non State Employer Human Resources Representative must write the words "Not Available" in the Employee Signature blank.

2. All Change Forms that are submitted to the SEHP Membership Services must have the Non State Employer Personnel Officer Authorization blanks completed prior to submitting the form.

CHAPTER 11 - MID-YEAR ENROLLMENT CHANGES

I. ADDITION AND DELETION OF NON-NEWLY ELIGIBLE EMPLOYEES AND OTHER INDIVIDUALS

Non-newly eligible employees and other individuals are defined as:

Employees and/or spouses and dependents for which 31 days have passed since their initial eligibility for coverage (see **Chapters 3 and 4**).

Non-newly eligible employees and/or spouses and dependents may be added or dropped from the SEHP during the Plan Year but only if all of the following mid-year change requirements are met:

A. The change is a result of one of the events listed in Section III or IV of this chapter;

B. The change is requested, by the employee/member within 31 calendar days of the event (by completing an Enrollment or Change Form) and received by SEHP Membership Services within 10 days of completion;

C. The change in coverage is consistent with the event and complies with HIPAA regulations; and

D. Written supporting documentation of the event is provided (divorce decree, death certificate, court ordered custody agreement, or statement from a spouse's employer on their letterhead).

Appropriate Supporting Documentation

The following items are appropriate supporting documentation required to be submitted to the SEHP with the Enrollment or Change Form when adding or removing other eligible individuals:

1. Marriage License in English (for proof of spouse and stepchild eligibility)
2. Birth certificate or hospital birth announcement in English for newborns
3. Petition for adoption or placement agreement in English for dependent child
4. Legal custody or guardianship document issued by the court
5. Court order for dependents who are not natural or adopted children of the member
6. Certificate of birth and Dependent Grandchild Affidavit for children born to a covered dependent (grandchild) (see **Appendix K**)
7. An Application for Coverage of Permanent and Totally Disabled Dependent Child affidavit for covered dependent children aged 26 or older (see **Appendix L**).

8. Copies of the most current year's filed Federal tax return **(for proof of spouse eligibility only).** The pages needed from the current filed Federal tax returns depend on which Tax form was filed:
    - Form 1040—pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
    - Form 1040A-- pages 1 & 2 showing filer's name, spouse's name and both the filer's and spouse's signatures
9. Divorce decree in English (first and last page only of court document)
10. A copy of a military ID and privilege card with the expiration date is acceptable as proof of Tricare coverage and to document the end of Tricare coverage.
11. A letter on company letterhead detailing loss of group coverage, date of loss and names of all dependents losing coverage.

In order to match other eligible individual documentation to the appropriate member, the Non State Employer Human Resources Representative must verify prior to sending the documentation to the SEHP, that the member's name, employee ID, and the Non State Group Number is clearly written on top of each document.

Additions: If dependent medical coverage is added, then dependent dental coverage may be added at the same time. If dependent dental coverage is elected, the level of dependent dental coverage must match the dependent medical coverage level. If the member currently has any level of dependent medical, but has member only dental, they may not elect to add dependent dental even with a qualifying event.

Vision coverage may be added during the Plan Year only for newly eligible employees and/or dependents. Members cannot change from Basic to Enhanced vision coverage, or vice versa during the Plan Year.

If the member has waived vision coverage, newly eligible dependents may not be added even if a qualifying event occurs.

Deletions: Members who are enrolled on an after-tax basis may drop member or dependent coverage (both medical and dental) without restriction during the Plan Year.

Dependent dental coverage may not be dropped during the Plan Year unless dependent medical coverage is also dropped.

Vision coverage may not be dropped during the Plan Year unless due to an ineligible member and/or dependent. Even if a member is enrolled on an after tax basis, vision coverage cannot be dropped during the Plan Year.

II. EFFECTIVE DATE OF COVERAGE

For mid-year enrollment changes, the effective date of coverage or change in coverage will generally be the first day of the month following the event (assuming all form requirements have been met). For events that occur on the first day of a month, the coverage effective date will be that day. However, if a death occurs on the first day of a month, the change effective date will be the first day of the following month.

In **Chapter 4, Section III B**, the effective date of coverage is outlined for newborns, adopted children, new spouses and/or new stepchildren, and changes in legal custody or guardianship of a dependent.

If a member is enrolled on an after-tax basis, and is dropping member and/or dependent coverage, the effective date of change in coverage is the first day of the month following completion of the Change Form (if the Change Form is received by SEHP Membership Services within 10 days of completion). If the Change Form is completed on the first day of a month, the coverage effective date will be that day.

The effective date of coverage or change in coverage is outlined in **Chapter 5** for changes in Medicare eligibility.

III. PRE-TAX EVENTS

If a member is enrolled on a pre-tax basis, and any addition or deletion to coverage will result in a change in employee contribution, there must be a qualifying event for the change to be approved. Enrollment changes must also be consistent with the event and must comply with HIPAA regulations. Members may change pre-tax status only during Open Enrollment each year (unless the 30 day waiting period was waived for initial enrollment). The change in status event must result in a gain/loss/change of coverage in an **employer-sponsored group health insurance plan**. This gain/loss/change can be for the employee, spouse, or dependent and can be under either the SEHP or a plan sponsored by the spouse or dependent's employer. The requested change of election must then correspond with the gain/loss/change of coverage, and must be confirmed with documentation in the form of a letter from the Non State Employer on the Non State Employer's letterhead. All changes must be requested within 31 days of the event and received by SEHP Membership Services within 10 days of the member's signature.

Members who are enrolled in the SEHP on a pre-tax basis may make mid-year additions and deletions from coverage based on the following events and subject to the requirements listed in **Section I**:

A. Employee's marriage – the member may add or drop entire family if the family is picked up under the new spouse's employer's plan because the entire family is now newly eligible (see **Chapter 4, Section III**). The entire family is not newly eligible for SEHP coverage if the spouse's employer covered unmarried domestic partners. If the marriage is a common law marriage, a notarized copy of the Affidavit of Common Law Marriage (**Appendix M**) must be included with the Enrollment or Change Form.

B. Final divorce (the first and last pages of the final divorce decree must be attached to the Enrollment or Change Form).

C. Birth or adoption of a dependent – the member may add entire family. May drop entire family only if the qualifying event is due to a birth or adoption, and those family members are now newly eligible under some other employer's plan (see **Chapter 4, Section III**).

D. Gain or loss of legal custody of a dependent.

E. Change from part-time to full-time or from full-time to part-time employment by employee, spouse or dependent that affects cost, benefit level, or benefit coverage for employee, spouse and/or dependents. Change from benefits eligible position to benefits ineligible position by the employee, spouse or dependent. Termination or commencement of employment (includes retirement) of employee, spouse or dependent which affects benefits coverage for employee, spouse and/or dependents (an employee may change their medical plan at the time of retirement) – (see **Chapter 17 Section IV**). Any employment status changes that affect eligibility.

F. Unpaid leave of absence by employee, spouse or dependent which affects the benefits coverage of employee, spouse and/or dependents (see **Chapter 12**). If the employee is rehired or reactivated within 30 days, he/she must return to the same plans and coverage levels unless he/she experiences a status change event.

G. Significant changes in the health insurance coverage of the employee, spouse or dependent. Change of Network Status of a physician is not a qualifying event. An employee can make a mid-year change due to an Open Enrollment change made by a spouse or dependent on their health plan.

H. Employee, spouse or dependent being called to active military duty and/or gaining or losing eligibility for military insurance.

I. Loss of COBRA eligibility (for other than non-payment of premium) from a previous employer for an employee, spouse or dependent.

J. Death of a spouse or dependent.

K. Dependent turning age 26 (coverage will end the last day of the month of the birthday). If the birth date is on the first day of a month, the coverage ending date for that dependent will be the last day of the preceding month.

L. Employee, spouse or dependent gaining or losing government-sponsored medical card coverage, although terminating coverage is not allowable if the employee becomes covered under programs like SCHIP (State Children's Health Insurance Program) because these programs are not supposed to replace existing insurance. This may apply to other government card coverage.

M. Employee, spouse or dependent losing Medicare eligibility or becoming eligible for Medicare, and electing Medicare coverage as primary (see **Chapter 5**).

N. Dependent children identified under a Medical Withholding Order (K.S.A. 23-4,105) or Qualified Medical Child Support Order (the SEHP has the authority to add these dependent children without the consent of the employee).

O. Court Order requiring adding or dropping coverage for a dependent child.

P. Dependent children losing eligibility/coverage under another group health insurance plan.

IV. AFTER-TAX EVENTS

Members who are enrolled in SEHP coverage on an after-tax basis may make mid-year additions and deletions from coverage due to the following events and subject to the requirements listed in **Section II**:

A. All events as listed under Pre-tax Events;

B. Removing employee, spouse, and/or dependents from SEHP coverage for any reason.

C. Vision coverage may **NOT** be added or dropped during the Plan Year.

V. RETIREMENT

When an employee retires from a participating Non State Employer Group, the employee must indicate on a Change Form whether or not they wish to continue SEHP coverage with the State of Kansas through the Direct Bill program. They will also be offered COBRA continuation coverage. If they have indicated on the Change Form that they wish to continue coverage through the Direct Bill program, the employee should ignore the COBRA notice. For additional information on the Direct Bill program (see **Chapter 17**). Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Change Form should be completed 30 days before the employee's retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage. The Change Form needs to indicate if the member's premium is subsidized or non-subsidized by the Non State Employer Group.

The effective date of change to the Direct Bill program will be the first day of the month following the employee's last day at work. The retiree will receive a bill for the first full month in retirement status if bank draft information is not received in time to get the automatic bank draft started. For the next month and after, individuals enrolled in the Direct Bill program must pay by bank draft. Deductions will be made from the individual's bank account on approximately the 3rd of the month for that month's coverage (i.e. January 3rd for January's coverage).

The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may be added to coverage only if there is a qualifying mid-year event (see **Chapter 11**). Dependents may also be added to coverage during the next Open Enrollment period. If the employee or covered spouse is age 65 or over when the employee retires, refer to **Chapter 5**.

VI. ACTIVE MILITARY DUTY

These procedures apply only if the participating Non State Employer Group wishes to cease employer contribution when an employee is on military leave.

Employee coverage ends effective the last day of the month in which the employee goes on military leave.

Employees on military Leave Without Pay may continue coverage for the next 30 days. The Non State Employer will continue to make the SEHP employer contribution for those 30 days.

The employee is required to remit his/her premium (regular payroll deduction amount) to the Non State Employer to retain coverage during the 30 days following the effective date of the military Leave Without Pay. If the Non State Employer wishes to continue paying the SEHP coverage premiums, they should continue to do so. No addition forms or information needs to be sent to the SEHP.

Employees may continue coverage in the SEHP beyond the 30 days Leave Without Pay timeframe if the Non State Employer discontinues making employer contributions to coverage, but the employee must remit the full premium amount directly to the premium billing vendor as a Direct Bill participant. There will be no Non State Employer contribution. An employee with spouse, children, or full family coverage may elect to drop themselves and keep their spouse and/or children covered in the SEHP. Employees must make the change within 30 days of the effective date of the military Leave Without Pay. To continue SEHP coverage, a Change Form indicating Leave Without Pay must be completed and submitted to the SEHP Membership Services within 10 days of the member's signature. Employees are also eligible for 24 months of COBRA coverage.

If SEHP coverage is continued, it will be the primary payer of claims and their military coverage will be secondary.

Members, their spouses and/or dependents who elect to discontinue SEHP coverage and who have primary coverage provided by the military will be allowed to re-enroll into the same SEHP plan and coverage when they return to active employee status.

Employees on military leave during Open Enrollment may enroll in any SEHP plans and coverage levels for which they are eligible, without penalty, upon their return to active employee status. The effective date of coverage may be either the first day of the month following the employee's return from active military duty or the first day of the month in which the employee returns to active employee status.

If an employee is qualified for and elects to participate in the military's transitional health benefit program, the employee will be allowed to reinstate SEHP coverage without penalty when the transitional coverage terminates. The employee may be qualified for up to 180 days of transitional health benefits.

The effective date of coverage may be either the first day of the month following termination of the military transitional health coverage or the first day of the month after the date the member returns to work, whichever the employee chooses.

Return from military leave policies also apply to spouses and dependents returning from military leave.

VII. TREATMENT FOR MEMBERS AND THEIR ELIGIBLE SPOUSE AND DEPENDENTS WHILE TRAVELING OUTSIDE OF THE U.S.

Members should contact their plan carriers **before** traveling outside of the U.S. for coverage and claim submission requirements in the event the member and/or their eligible spouse and dependents needs to seek medical treatment while traveling outside of the U.S. Each plan

carrier has their own processes and procedures to ensure the member and/or their eligible spouse and dependents have appropriate coverage while traveling.

VIII. PRESCRIPTION DRUG ADVANCE PURCHASE POLICY:

A. Travel in the United States

Because the SEHP uses the Caremark Pharmacy network, members traveling within the United States are not eligible for an advance purchase. SEHP members may use their drug card at any Caremark network pharmacy throughout the U.S.

B. Travel Outside of the United States

1. Travel or work outside the U.S. for a period of sixty (60) days or less:

Members that leave the U.S. for 60 days or less may call the toll-free number on the back of their card to arrange for a vacation supply of medications. Caremark may enter up to 30 days on an original fill for non-controlled and controlled medications or a 60 day override on refills of medications as allowed by the benefit description. The member will be billed the applicable coinsurance or copayment for the quantity purchased.

2. Work outside the U.S. for a period of sixty (60) days or longer (but not to exceed one (1) year):

This policy and its provisions apply only to active employees covered under the SEHP. When a member will be outside of the country for a longer period of time, there are two options available:

- **Advance purchase through drug plan:**

The member must work with the Non State Employer personnel/benefits office to arrange for advance purchase of maintenance medications required during a stay outside the U.S. The Advance Purchase Certificate (see **Appendix G**) certifying that health coverage will be maintained during the entire period of the extended absence must be signed by both the member and the Non State Employer. An Advance Purchase Form must be submitted to Membership Services in the SEHP **at least fifteen (15) days prior to departure date**. The Non State Employer and the member will be notified when the Advance Purchase Form has been processed and the dates the medication will be available to pick up. Generally, the medication will be available for purchase one week in advance of the departure date. The following requirements apply:

(1) The Advance Purchase form must be completed stating that coverage will be maintained via payroll deductions during the term outside of the U.S. The form also requires information on destination and duration of stay. The Advance Purchase form signed by the member and the Non State Employer personnel representative acknowledges the SEHP's right to recovery from the Non State Employer and/ or employee the cost of the medications if coverage is not maintained.

(2) The name and strength of each requested medication and the name of the prescribing doctor must be on the Advance Purchase form. For each medication, provide the name of pharmacy where the medication

will be filled. The member will be responsible for the applicable coinsurance percentage on the cost of the quantity of drug dispensed. The member must agree to purchase the prescription medication at a local network pharmacy. Members or their dependents using the Caremark mail service will need to obtain a prescription from their doctor so that the items can be purchased at a local network pharmacy. **REMINDER:** Medication can only be dispensed for the period of time allowed by the prescription written by the provider. For extended periods, the member may need a new prescription. Advance purchases are available for period up to one (1) year.

(3) Benefits available for emergency prescriptions purchased outside of the U.S. will be limited to those drugs which would have been covered had they been purchased within the U.S. Documentation of the purchase must be translated into English along with the exchange rate on the date of service and be submitted to the SEHP on a paper form (See **Appendix H***)* with a statement indicating their purchase and use while outside of the U.S. Membership status will be verified and the claim will be forwarded to Caremark for reimbursement.

- **Member purchases medication(s), then submits claim(s) upon return:**
  If the member does not have enough time to file an Advance Purchase Form in advance of their departure, they may pay the full price for their medications, and file a paper claim for reimbursement upon their return. The paper claim would need to be filed first to SEHP for processing.

For additional information, refer to **Appendix G-1.**

IX. DEATH OF A PRIMARY MEMBER WITH DEPENDENT CHILDREN

In the event of the death of a primary member who only had dependent child(ren) covered under their SEHP coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP Direct Bill program until they no longer meet the definition of an eligible dependent (i.e., the child reaches the limiting age of 26).

The eligible dependent child(ren) or authorized representative for the eligible dependent child(ren) must contact SEHP Membership within 31 days of the death of the primary member in order to elect to continue coverage under the Direct Bill program. If elected, the Direct Bill coverage will be set up under the youngest eligible dependent child as the primary member with other eligible dependent child(ren) set up as dependents under that new primary member.

CHAPTER 12 - LEAVE WITHOUT PAY AND FAMILY MEDICAL LEAVE ACT (FMLA)

The Federal Family and Medical Leave Act (FMLA) became effective August 5, 1993.

I. APPROVED LEAVE WITHOUT PAY

If a member is on voluntary or involuntary Leave Without Pay and the leave is not approved as FMLA AND the Non State Employer does not continue to make employer contributions to the SEHP coverage, the Non State Employer Human Resources Representative must submit a change form terminating the coverage the first of the month following the last date the employee was working. The Non State Employer must notify the member that their SEHP coverage as an active employee will end effective the last day of the month that the employee went on Leave Without Pay status unless the member signs up for Direct Bill.

The Non State Employer must treat an employee on FMLA as an active employee, making employer contributions for coverage for 12 weeks. No additional forms or information needs to be sent to SEHP Membership Services unless the member terminates coverage for any reason.

If the Non State Employer wishes to continue making employer contributions to the employee's SEHP coverage, they must also collect the employee's portion of the premium and submit premiums as normal to the SEHP's premium billing administrator. No additional forms or information needs to be sent to SEHP Membership Services unless the member terminates coverage for any reason.

A. Non-Payment of Active Non State Employee Premium

If the employee fails to pay on schedule, the Non State Employer Human Resources Representative shall submit a Change Form to SEHP Membership Services canceling the employee's coverage. The employee will not be offered COBRA continuation coverage and will not be allowed to re-enroll in active or Direct Bill coverage for the remainder of the Leave Without Pay period. **If the Non State Employer fails to submit a Change Form, it will be assumed the employee is still an active employee. If the Non State Employer fails to notify SEHP Membership Services of any cancellation within 31 days of the qualifying event, the Non State Employer shall be assessed a fee of $200.00 per member per month for every month the notice is not received by SEHP Membership Services. The notice must be received on a SEHP Change Form. The assessment itself is made payable to SEHP and sent to SEHP Membership Services.**

B. Continuing under the Direct Bill Program

If the employee elects to continue under the Direct Bill program, coverage will begin the first day of the month following the last day of work or the end of the month the NSE stopped making employer contributions to the SEHP coverage. A bill will be generated by SEHP's Direct Bill premium billing vendor, and sent to the member's home address the middle of each month before the Direct Bill premium for coverage is due. Premiums are due the first of the month for that month's coverage. The member pays the entire monthly premium (member and NSE portions) while on Direct Bill coverage.

C. Employee's Premium Responsibility

Non State Employer contributions toward coverage will be reinstated the first day of the month following the date in which the member returns to active status. If the member returns to work on the first day of a month, Non State Employer contributions will be reinstated that day. Once payroll deductions resume, the member will be refunded the Direct Bill monthly premium if payment has already been made for that month.

D. Billing and Payment Procedure

After the Change Form is received and processed by SEHP Membership Services, they will forward the enrollment change to the Direct Bill premium billing vendor. SEHP's Direct Bill premium billing vendor will calculate the necessary premium amounts and will send a bill to the member's last known home address. If the member desires to continue coverage, the member then remits the amount due. The Direct Bill monthly premiums are paid by the employee until the employee returns to work. Premiums are due on the first of each month for coverage for that month.

E. Changes in Coverage Level

The member may reduce coverage level while on Direct Bill during a period of Leave Without Pay, such as changing from family coverage to single coverage. No changes to coverage will be allowed, unless due to a qualifying event. Members cannot drop vision coverage when going on Direct Bill, but may do so at Direct Bill Open Enrollment. A member on Leave Without Pay during Direct Bill Open Enrollment may make any desired changes to coverage for the coming Plan Year.

F. Non-Payment or Late Payment of Premium

If any Direct Bill payment is not received within 15 calendar days of its due date, coverage will be terminated effective the first day of the month for which the payment was due.

II. RETURN FROM LEAVE WITHOUT PAY

When an employee returns from Leave Without Pay, an Enrollment Form must be completed within 31 days of the date of return to active pay status and received by SEHP Membership Services within 10 days of completion of the form;

A. An Enrollment Form should be completed for the current medical plan indicating "Return from Leave Without Pay" for the same level of coverage. The employee may enroll on a pre-tax basis in the same Plan Year if they were paying on a pre-tax basis before they went on Leave Without Pay. If spouse or dependent coverage was dropped during the Leave Without Pay:

1. The employee may add the previously covered spouse and dependents to coverage;

2. or; the employee may continue single coverage upon return to active pay status as outlined in II (A).

3. The effective date of coverage will be the first day of the month following the employee's return to active pay status. If the employee returns on the first day of a month, coverage will begin that day.

B. If the employee did not continue coverage under Direct Bill, or their premiums are not currently paid in full, an Enrollment Form must be completed and "Return from Leave" should be written on the Enrollment Form with the return date to active pay status. The effective date will be the first day of the month following the employee's return to active pay status. If the employee returns to work on the first day of a month, coverage will begin that day. The employee cannot change their medical plan unless the period of Leave Without Pay extended over Open Enrollment.

III. FMLA - APPROVED LEAVE WITHOUT PAY OF 31 DAYS OR MORE

If the employee is eligible for FMLA and has a qualifying condition as outlined in the FMLA, they are eligible for 12 weeks of paid or unpaid leave; during any 12-month period beginning with the first day leave was taken.

Documentation of leave under FMLA should be retained by the Non State Employer. When an employee goes on Leave Without Pay under FMLA, the Non State Employer Human Resources Officer must submit a completed Change Form for "Leave Without Pay" only after all leave under FMLA has been exhausted by the employee and the Non State Employer wishes to discontinue making employer contributions to the employee's SEHP coverage.

A. Billing and Payment Procedure

Premiums should continue to be deducted from the employee's paycheck for as long as the employee continues to receive a paycheck that is sufficient to take the SEHP deduction. When the payroll deduction is no longer taken, the employee is responsible for remitting the employee contribution amount due directly to the Non State Employer.

B. Changes in Coverage Level

A member on continuation under FMLA during Open Enrollment may also make changes to their SEHP coverage.

In addition, a member with a qualifying event may make the appropriate additions and/or deletions to coverage (e.g., adding a newborn child to coverage). Changes should be sent on a Change Form to SEHP Membership Services.

IV. RETURN FROM FMLA - LEAVE WITHOUT PAY

If an employee returns to work, but was terminated for non-payment of premium while on FMLA, they may re-enroll in their previous coverage. The effective date of coverage will be the first day of the month following the employee's return to active employment. If the employee returns to work on the first day of a month, coverage will begin on that day.

CHAPTER 13 - RETROACTIVE ENROLLMENTS

Retroactive enrollments are those in which notification is not made to the SEHP Membership Services within 31 days from the date of the qualifying event. Retroactive enrollments are also those in which notification is not received by the medical plans within 60 days of the date of the event.

REMINDER: Changes will not be made until a completed Change Form or Enrollment Form is received by the SEHP Membership Services. Changes in the monthly billing statements will not be accepted as fulfilling the Non State Employer Group's responsibility to notify the SEHP of a request for coverage changes. The Non State Employer Group will be responsible for all premiums that result from failure to provide proper notice to the SEHP in a timely manner.

Due to contractual agreements with the medical plans, retroactive enrollments must be processed as follows:

I. ENROLLMENT TERMINATIONS

Retroactive enrollment terminations are processed due to late notification of a qualifying event if the member **does not** wish to continue with the SEHP (e.g. termination, death, retirement, Leave Without Pay, change to an ineligible position or non-payment of premium). The termination will be made effective as of the first day of the month following the date of the qualifying event. **However, failure of the Non State Employer to notify the SEHP of any termination within 31 days of the qualifying event shall result in the assessment of a fee of $200.00 per member per month for every month the notice is not received by SEHP Membership Services. The notice must be received by SEHP Membership Services on an SEHP Change Form.** The SEHP will notify the Non State Employer Group of penalty amounts due.

Example: An employee terminates employment on April 19, 2xxx but the SEHP Membership Services does not receive a SEHP Change Form until October 18, 2xxx. The effective date of termination is April 30, 2xxx; **however the Non State Employer is responsible for the assessment fee of $200.00 per month** from May through October.

In the event that SEHP does not receive timely notification of a termination of employee/spouse/dependent benefits and the employee/spouse/dependent is eligible for and wishes to continue SEHP coverage under the Direct Bill program, retroactive enrollment may be allowed. The enrollment in the Direct Bill program will be made effective as of the first day of the month following the date of the qualifying event.

However, failure of the Non State Employer to notify the SEHP of any cancellation within 31 days of the qualifying event shall result in the Non State Employer being responsible for the member/spouse/dependent's Direct Bill premiums for every month the notice is not received. The notice must be received by SEHP Membership Services on an SEHP Change Form. The SEHP will notify the Non State Employer of penalty amounts due.

Example: An employee goes on Leave Without Pay effective April 19, 2xxx, but the Non State Employer does not notify SEHP Membership Services (by submitting a Change Form) until October 18,2xxx. The effective date of Leave Without Pay is May 1, 2xxx; **however, the Non State Employer is responsible for the back Direct Bill premiums from May through October.**

II. ENROLLMENT ADDITIONS

The Non State Employer must make requests for late retroactive enrollment additions on Non State Employer letterhead. If a late retroactive enrollment addition is approved, the Non State Employer is responsible for payments of the retroactive premiums from the effective date of coverage up to the date the enrollment addition is processed by SEHP Membership Services.

After 60 days have passed from the effective date of coverage, retroactive additions to coverage will not be made on any medical, prescription drug and dental plan unless a Communication Form (See **Appendix F**) is submitted to and approved by SEHP Membership Services. **Retroactive vision enrollment will not be approved.**

If necessary, the employee must complete a revised SEHP Enrollment Form, in order for the retroactive enrollment to be processed. If a revised Enrollment Form is required, the SEHP will notify the Non State Employer.

Example: A benefits eligible employee is hired on April 19, 2xxx and immediately completes an Enrollment Form for Plan A coverage effective July 1, 2xxx. The Non State Employer sends the Enrollment Form to SEHP Membership Services on September 10, 2xxx. Because the effective date of coverage is more than 60 days prior, the employee will be required to complete a revised Enrollment Form effective July 1, 2xxx indicating Plan A as the medical plan.

III. ENROLLMENT CHANGES DUE TO INELIGIBLE SPOUSE/DEPENDENTS

If a retroactive enrollment change is processed due to late notification of an ineligible spouse/dependent, the enrollment change will be made effective the first day of the month following the date of the event. Refunds will not be processed due to late notification.

CHAPTER 14 - TERMINATION OF COVERAGE

I. GROUP TERMINATION

The participating Non State Employer Group is responsible for advising terminating employees when their coverage will end. The participating Non State Employer Group's coverage through the SEHP terminates on the earliest of the following dates:

A. Upon termination of the SEHP group policy;

B. Upon non-payment of the required group premiums;

C. The date the Non State Employer Group ceases to participate in the SEHP; or

D. On the date the participating Non State Employer Group breaches it contract with the SEHP. This includes failing to maintain the participation level required by the contract.

1. Groups are required to complete a SEHP Certification Form (see **Appendix U**) and submit it to the SEHP by January 1 each year documenting their participation levels in the SEHP.

II. EMPLOYEE TERMINATION

The Non State Employer Human Resources Officer is responsible for advising terminating employees when their SEHP coverage will end. SEHP coverage for an employee terminates on the earliest of the following dates:

A. When the group policy terminates;

B. On the last day of the month for which premium payment was last received for the employee;

C. On the last day of the month in which the employee becomes ineligible for benefits; or

D. On the last day of the month in which an employee terminates employment except those:

1. Employees whose spouse is also employed by another participating Non State Employer Group and has enrolled the former employee as a dependent; or

2. Employees who are eligible to continue upon cessation of active work:

   a. Employees granted Leave Without Pay.

b. Individuals who are eligible to continue coverage by reason of retirement as indicated by K.A.R. 108-1-3 and 108-1-4.
c. Twelve (12) month contract teachers.

If the terminating employee is Medicare eligible for any reason, (age 65, disabled, etc.), the NSE must provide them with a Memo for Medicare Part B, (Appendix I), on the NSE's letterhead. This Memo is for the employee to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The memo should be provided to the employee upon their termination, or mailed to the employee's last known address.

III. OTHER ELIGIBLE INDIVIDUALS TERMINATION

SEHP coverage for other eligible individuals terminates on the earliest of the following dates:

A. When the group policy terminates;

B. The last day of the month in which an employee's coverage terminates; or

C. The last day of the month in which the individual ceases to be an eligible spouse or dependent under the SEHP's definition of an eligible spouse or dependent.

1. For terminations other than termination of employment, if the event that causes the spouse or dependent to lose eligibility occurs on the first of the month, then that is the last day of coverage.

   Examples (but not limited to these situations):

   - Dependent turns 26 on August 1; their coverage terminates on August 1.
   - Divorce occurs on August 1; spouse's coverage terminates on August 1.

If the member's spouse or dependent is terminating SEHP coverage and is Medicare eligible for any reason, (age 65, disabled, etc.), the NSE must provide the member with a Memo for Medicare Part B, (Appendix I), on the NSE's letterhead. This Memo is necessary for the spouse/dependent to provide to the Social Security Administration to allow them to apply for Medicare without incurring any penalties. The Memo should be provided to the member upon the termination of the spouse/dependent, or mailed to the member's last known address.

CHAPTER 15 – BILLING AND PAYMENT

I. BILLING AND PAYMENT FOR PARTICIPATING NON STATE EMPLOYER GROUPS

The SEHP uses HP Enterprises, Inc as its third party billing administrator for participating Non State Employer Groups. HP Enterprises, Inc sends the billing statement to participating Non State Employer Groups around the 25th of the month prior to the coverage period. Non State Employer Groups may also sign up for automatic draft payment through HP Enterprises, Inc.

The billing statement includes a detailed list of covered members, their enrollment level and amount due for coverage. Payment is due by the 10th day of the month for the coverage period.

If there are corrections to the billing, the Non State Employer Human Resources Representative can make a line through any incorrect information on the statement, mark the corrections needed and note the reason for the correction on the bottom of the page.

The Non State Employer Group must ensure that any changes for employees' coverage are made on appropriate enrollment or change forms as outlined in **Chapters 3, 4, 10 and 11**.

The Non State Employer Group must pay the billed "Grand Total" amount each month. The Non State Employer Group should not change the amount paid and pay what they feel is correct.

Adjustments will be reflected the following month in the adjustment section of the billing report. If there are errors in the adjustment section greater than $2,500 dollars call the SEHP Fiscal Management for permission to pay a lesser amount. Send a copy of the corrected billing along with your payment. Enrollments and changes processed after the effective date will be adjusted on the next month's draft. For questions on billing, contact the SEHP Fiscal Management (785) 296-3667.

Payment checks should be made out to "HP Enterprises, Inc" and sent to HP at the address listed on the billing invoice.

Reminder: Changes in coverage **will not** be made until the completed Enrollment or Change Form is received by the SEHP Membership Services. Crossing an employee off the monthly billing statement **will not** be accepted as fulfilling the Non State Employer Group's responsibility to notify the SEHP of a request for coverage changes.

CHAPTER 16 - HIPAA

I. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health insurance coverage for workers and their families when they change or lose their jobs. HIPAA places requirements on employer-sponsored group health plans, insurance companies and health maintenance organizations that:

1) limit exclusions for pre-existing conditions;
2) prohibit discrimination against employees and dependents based on their health status; and
3) guarantee renewability and availability of health coverage to certain employees and individuals.

A. PRE-EXISTING CONDITION EXCLUSIONS

Prior to HIPAA, group sponsored plans limited or denied coverage of conditions that were present prior to an individual's enrollment in that health plan. These restrictions were referred to as "pre-existing condition exclusions". HIPAA places strict limitations on such exclusions. For example, plans are required to provide notice of pre-existing condition exclusions; a pre-existing condition exclusion must relate to a condition for which medical advice, diagnosis, or treatment was recommended or received during the 6-month period prior to an individual's enrollment date in the plan; coverage can only be excluded for a maximum period of 12 months (18 months for late enrollee), and reduce the 12/18 month exclusion period by the amount of time an individual had certain other insurance coverage (called "creditable coverage"). Other benefit limitations or restrictions may apply under health plans, such as the Uniformed Services Employment and Reemployment Rights Act (USERRA), which can affect the application of pre-existing condition exclusion to certain individuals who are reinstated in a group health plan following active military service. With HIPAA, certain people and conditions can never be subject to pre-existing condition exclusion, for example pregnancy. Under HIPAA, the enrollment date is the first day of coverage or, if there is a waiting period, the first day of the waiting period.

B. CREDITABLE COVERAGE

The group health plan is required to furnish a certificate of coverage automatically when coverage terminates either with the SEHP or when coverage is lost under COBRA continuation, as well as upon an individual's written request at any time while that person is covered by a plan or up to 24 months after coverage ceases. Plans are also required to use reasonable efforts to determine information needed to complete a certificate for a dependent. Creditable coverage is coverage under most health benefit programs, including employer or multiemployer group health plans, individual health insurance policies, COBRA continuation coverage, Medicare, Medicaid, and state and local government programs, including health coverage provided by SCHIP and by a foreign government. Certification will be sent to the individual or dependent at their last known address and will identify the covered person, the period of

coverage, any waiting periods, and will include an educational statement to inform recipients of their HIPAA rights, and information about FMLA coordination. Also under the Trade Act of 2002, workers qualifying for the provisions of the Trade Act have a second opportunity to elect COBRA after an original qualifying event.

C. SPECIAL ENROLLMENTS

HIPAA requires that group health plans allow individuals to enroll without having to wait for late or open enrollment. These special enrollment periods are for individuals who previously declined coverage for themselves and their dependents. A special enrollment period can occur if: (1) a current employee or dependent with other health coverage loses eligibility for coverage, or (2) a person becomes a dependent through marriage, birth, adoption or placement for adoption. The employee needs to complete enrollment within 31 days after their other coverage ends. Written documentation of the marriage, birth, adoption or placement for adoption must be provided. (Please refer to **Chapters 3 and 10** for more information).

Some examples where special enrollment would apply are: 1) ceasing to be eligible under a plan due to cessation of dependent status (e.g. a child aging out of dependent coverage); 2) reaching a plan's lifetime limit on all benefits; 3) a plan ceasing to offer any benefits for a class of similarly situated individuals (e.g. all part-time workers); and 4) an employer of another plan stops contributions toward other coverage, even if the individual continues the other coverage by paying the amount that used to be paid by the employer.

D. NON-DISCRIMINATION REQUIREMENTS

Individuals may not be denied eligibility or continued eligibility to enroll for benefits under the terms of the plan based on specified health factors. In addition, an individual may not be charged more for coverage than similarly situated individuals on these factors. These factors are: health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, and evidence of insurability or disability. For example, an individual cannot be excluded or dropped from coverage under the health plan just because the individual has a particular illness.

E. OTHER APPLICATIONS OF HIPAA LAW

HIPAA provisions also apply to services under the following laws: 1) Women's Health and Cancer Rights Act (WHCRA) which provides protections to patients who choose to have breast reconstruction in connection with a mastectomy; 2) Mental Health Parity Act (MHPA) which prevents the group health plan from placing annual or lifetime dollar limits on mental health benefits that are lower - less favorable - than annual or lifetime dollar limits for medical and surgical benefits offered under the plan; and, 3) Newborns' and Mothers' Health Protection Act (NMHPA) which affects the amount of time the member or beneficiary and newborn child are covered for a hospital stay following childbirth. For the mother or newborn child, that includes no restriction to less than 48 hours following a normal vaginal delivery or less than 96

hours following a cesarean section. Nor is it required that a hospital obtain authorization from the medical plan for prescribing a length of stay not in excess of the above periods.

F. PLAN DISCLOSURE REQUIREMENTS

Under the Department of Labor's (DOL) rules governing plan disclosure requirements, group health plans must improve the summary plan descriptions and summaries of material modifications in the following ways: 1) Notify members and beneficiaries of any material reductions in covered services or benefits within 60 days of adoption of the change; 2) Disclose information about the role of insurance companies and health plans with respect to the group health plan, specifically the name and address, and to what extent benefits under the plan are under a contract, and the administrative services, such as paying claims; 3) Inform members and beneficiaries which DOL office they can contact for assistance or information on their rights under HIPAA; and 4) Inform members and beneficiaries that federal law prohibits the plan and health insurance issuer from limiting hospital stays for childbirth to less than 48 hours for normal deliveries and 96 hours for cesarean sections.

G. PLAN MEMBERS RIGHTS

Should a member have questions about their rights under HIPAA, they may contact the following office:

U.S. Department of Labor
Employee Benefits Security Administration
City Center Square, 1100 Main Street
Kansas City, Missouri 64105
Telephone: 816-426-5131

The member may also contact:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, D.C. 20210

II. HIPAA ADMINISTRATIVE SIMPLIFICATION

The Administrative Simplification provisions of the HIPAA (Title II) require the Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. It also addresses the security and privacy of health data. Adopting these standards improves the efficiency and effectiveness of the nation's health care system by encouraging the widespread use of electronic data interchange in health care.

A. PRIVACY REGULATIONS

The privacy regulations (effective April 14, 2003) ensure a national floor of privacy protections for patients by limiting the ways that health plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is on paper, in computers or communicated orally. Key provisions of these standards include: 1) Access to medical records; 2) Notice of privacy practices; 3) Limits on use of personal medical information; 4) Prohibition on marketing, and stronger state laws; 5) Confidential communications; and 6) Where to file complaints.

B. SECURITY REGULATIONS

The HIPAA Security requirements (effective April 20, 2005) ensure confidentiality of electronic protected health information that the health plan creates, receives, maintains or transmits.

C. SPECIAL NOTES:

- At times it may be necessary to obtain information regarding a member's protected health information. SEHP will request that the member complete an Authorization for Release of Protected Health Information form (see **Appendix R**).
- Members may complete an Appointment of Personal Representative Form (see **Appendix S**) and submit it to SEHP Membership Services to allow another individual to discuss and act on behalf of that member regarding their coverage under the SEHP. Without this form, the SEHP will not discuss anything or act upon any requests from any individual other than the member regarding a member's SEHP coverage.
- If a member currently has a Personal Representative Form on file with the SEHP and no longer wishes to have that individual act on behalf of a member, the member must submit a Revocation of Personal Representative Form (see **Appendix S-1**) to SEHP Membership Services.

CHAPTER 17 - CONTINUATION OF COVERAGE – DIRECT BILL PROGRAM

I. MEMBERS ELIGIBLE TO CONTINUE IN THE DIRECT BILL PROGRAM

Eligible members may continue coverage through the SEHP after they retire from the participating Non State Employer Group. Coverage will continue in the SEHP for as long as the participating Non State Employer Group is covered under the Plan. If a participating Non State Employer Group elects to terminate coverage in the SEHP, the Direct Bill members from that Non State Employer Group would be terminated as well.

NOTE: If a retiree is hired by a participating Non State Employer Group and did not previously retire from an employer that was part of the SEHP, the retiree may not participate in the SEHP Direct Bill program upon terminating employment from the Non State Employer Group because they did not retire from the State of Kansas originally.

The following members are eligible to continue under the SEHP Direct Bill Program:

Subject to the provisions of subsection (e) of K.A.R. 108-1-3 and 108-1-4, the classes of persons eligible to participate as members of the SEHP on a Direct Bill basis shall be those classes of persons listed below:

A. Any retired school district employee who is eligible to receive retirement benefits;

B. Any totally disabled former school district employee who is receiving benefits under K.S.A. 74-4927 and amendments thereto;

C. Any surviving spouse or dependent of a qualifying member in the school district plan;

D. Any person who is a school district employee and who is on approved Leave Without Pay in accordance with the practices of the qualified school district;

E. Any individual who was covered by the health care plan offered by the qualified school district on the day immediately before the first day on which the qualified school district participates in the school district plan, except that no individual who is an employee of the qualified school district and who does not meet the definition of school district employee in K.A.R 108-1-3

F. Any retired local unit employee who meets one of the following conditions:

1) The employee is eligible to receive retirement benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or

2) if the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police and firemen's retirement system, the employee is eligible to receive retirement benefits under the retirement plan provided by the qualified local unit;

G. Any totally disabled former local unit employee who meets one of the following conditions:

1) The employee is receiving benefits under the Kansas Public Employees Retirement System or the Kansas police and firemen's retirement system; or

2) if the qualified local unit is not a participating employer under either the Kansas Public Employees Retirement system or the Kansas police and firemen's retirement system, the employee is receiving disability benefits under the retirement or disability plan provided by the qualified local unit.

H. Any surviving spouse or dependent of a qualifying member in the local unit plan

I. Any person who is a local unit employee and who is on approved Leave Without Pay in accordance with the practices of the qualified local unit; and

J. Any individual who was covered by the health care plan offered by the qualified local unit on the day immediately before the first day on which the qualified local unit participates in the local unit plan, except that no individual who is an employee of the qualified local unit and who does not meet the definition of the local unit employee in K.A.R. 108-1-4.

II. CONDITIONS FOR DIRECT BILL MEMBERS

Each person who is within a class listed above will be eligible to participate on a direct bill basis only if the person meets both of the following conditions:

1) The person was covered by the qualified school district plan or the health care insurance plan offered by the qualified school district on one of the following bases:

a) Immediately before the date the person ceased to be eligible for coverage, or for any person identified in paragraph E. above immediately before the first day on which the qualified school district participates in the school district plan, the person either was covered as an active member or was covered by the health care insurance plan offered by the employee's qualified school district.

b) The person is a surviving spouse or dependent of an active or Direct Bill member who was enrolled when the primary member died, and the person was enrolled in the health care benefits program as a dependent when the primary member died.

c) The person is a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by the member's qualified school district when the member died, and the person has maintained continuous coverage under the qualified school

district's health care insurance plan before joining the health care benefits program.

2) The person completes an enrollment form requesting transfer to the Direct Bill program and submits the form to the SEHP. The form must be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph E. no more than 30 days after the first day on which the qualified school district participates in the school district plan.

3) The person was covered by the qualified local unit plan or the health care insurance plan offered by the qualified local unit on one of the following bases:

   a) Immediately before the date the person ceased to be eligible for coverage, or for any person identified in paragraph J. above immediately before the first day on which the qualified local unit participates in the local unit plan, the person either was covered as an active member or was covered by the health care insurance plan offered by the employee's local unit.

   b) The person is a surviving spouse or dependent of an active or Direct Bill member who was enrolled when the primary member died, and the person was enrolled in the health care benefits program as a dependent when the primary member died.

   c) The person is a surviving spouse or dependent of a primary member who was enrolled under the health care insurance plan offered by the member's qualified local unit when the member died, and the person has maintained continuous coverage under the qualified local unit's health care insurance plan before joining the health care benefits program.

4) The person completes an enrollment form requesting transfer to the Direct Bill program and submits the form to the SEHP. The form must be submitted no more than 30 days after the person ceased to be eligible for coverage, or in the case of any individual identified in paragraph J. no more than 30 days after the first day on which the qualified local unit participates in the local unit plan.

5) Continuation of benefits (COBRA) coverage. Any individual with rights to extend coverage under provisions of public law 99-272, as amended, may participate in the school district plan, subject to the provisions of that federal law.

III. PAYMENT METHODS UNDER THE DIRECT BILL PROGRAM

Members who are eligible to continue coverage under the SEHP may pay their premiums by any of these methods:

- Bank draft (See **Appendix T**)
- Online
- Telephone
- Check or money order

A Welcome letter from the SEHP's Direct Bill premium billing vendor will be sent to the member with their first bill. This letter also outlines the above payment options available to the member.

Premium payments are due the first of the month for that month's coverage. Payment will be considered late if not received by the 15th of the month and coverage will be terminated back to the first of that month.

For additional information concerning the Direct Bill program, the Non State Employer Human Resources Representative or the member should contact:

Membership Services
State Employee Health Plan
900 SW Jackson, Suite 900
Topeka, Kansas 66612-1220
Telephone: 1-866-541-7100 (Toll Free)
785-296-1715 (In Topeka)
Fax: 785-368-7180

IV. RETIREMENT, SEHP BENEFITS AND MEDICARE ELIGIBILITY

A. RETIREMENT

When an employee decides to retire, the employee needs to take the following steps:

1. Notify their Non State Employer of their date of retirement at least 90 days before the effective date.

2. Decide if they wish to continue with the SEHP coverage after retirement.

   NOTE: Retirement is considered a termination of employment and therefore makes the participating member and their covered dependents eligible to continue their SEHP coverage under COBRA. The member and their covered dependents will automatically receive a COBRA qualifying event notice from the SEHP's COBRA administrator (Please see **Chapter 20**, Continuation of Coverage – COBRA for further information).

   The member and their dependents should only choose to continue their coverage under the SEHP Direct Bill program or COBRA continuation; **not both**. If the member and their dependents elect to continue their SEHP benefits under the Direct Bill program, the member should ignore the COBRA qualifying event notice. This prevents the member from being charged for 2 coverage plans.

3. If the member decides to enroll in the SEHP Direct Bill program and the member and/or spouse are Medicare eligible, they must indicate the Medicare plan they wish to enroll in.

4. If Medicare eligible, the member must be enrolled in both Parts of Medicare (Part A & B). If only enrolled in Part A, obtain **Appendix I** from their Non State Employer to take to their local Social Security office to enroll in Medicare Part B.

5. If the member is electing Kansas Senior Plan C, they must determine if they wish to maintain the SEHP drug coverage. If the member does not keep the SEHP drug coverage, they need to obtain a letter of creditable coverage from SEHP.

6. Decide if they wish to maintain the SEHP dental coverage. If the member elects to opt out of dental coverage at the time of retirement, they **cannot** re-enroll in SEHP dental coverage at a later date.

7. Vision coverage may not be dropped for the member, their spouse or dependent at retirement or during the plan year unless a spouse or dependent becomes ineligible or unless all coverage is terminated. If dependent medical is dropped, dependent vision coverage can be dropped.

8. Include a copy of all applicable Medicare cards or a letter from Social Security indicating their Medicare number and effective dates for Medicare Parts A and B.

When an employee retires, the Non State Employer Human Resources Representative needs to take the following steps:

1. Ask the employee if they wish to continue their SEHP coverage under the SEHP Direct Bill program or COBRA continuation. If the member wishes to continue under COBRA continuation, please refer to **Chapter 17,** Continuation of Coverage – COBRA for further information. If the employee wishes to continue their SEHP under the SEHP Direct Bill program, please continue below.

2. Ask employee if they or any covered spouse or dependent is Medicare eligible.

3. If needed, provide the member with the **Appendix I** memo, Creditable Coverage letter, Direct Bill Enrollment booklet and charts including Medicare plan options if applicable.

4. Complete the Change Form for retirement.

5. Indicate the medical coverage the member wishes to be enrolled in after retirement. Provide the member with their Medicare Plan Options if applicable.

6. Indicate on the Change Form if the member is eligible for split coverage (See Split Enrollment section below). Be sure to list the medical coverage that both the member and the dependent(s) [spouse and/or child(ren)] wish to be enrolled in.

7. Ask member if they want to opt out of dental coverage. Remember to inform them that if they opt out of the dental coverage, they **cannot** re-enroll in the SEHP dental coverage at a later date. If the member elects to opt out of dental coverage, this must be indicated on the Change Form.

8. If Medicare eligible, indicate whether the member and dependent(s) [spouse and/or child(ren)] are continuing their SEHP drug coverage. If so, then indicate the prescription drug coverage election for the member and dependent(s) [spouse and/or child(ren)]. If the member elects to drop SEHP drug coverage, this must be indicated on the Change Form.

9. Ensure that the member has signed and dated the Change Form.

10. Ensure that the appropriate supporting documentation has been provided by the member and is included with the Change Form. In order to match spouse and dependent documentation to the appropriate member, the Non State Employer Human Resources Representative must verify prior to sending the documentation to the SEHP, that the member's name, employee ID, and the Non State Group Number is clearly written on top of each document.

11. Ensure that the Non State Employer Human Resources Representative has signed and dated the Change Form.

12. Forward the completed Change Form and appropriate supporting documentation to SEHP Membership Services within 10 days of the member's signature.

REMINDERS:

a. **NOTE: Effective January 21, 2001, a person will not be eligible for Direct Bill coverage if they do not maintain continuous coverage with the SEHP. This is in accordance with K.A.R. 108-1-3 and K.A.R 108-1-4.**

b. Members must have continuous coverage under the SEHP to be eligible for the Direct Bill program. If continued coverage is desired, the Change Form must be completed 90 days before the employee's retirement in order to ensure continuous coverage between active employee coverage and Direct Bill coverage.

c. The employee may change their medical plan at the time of retirement. Dependents may be dropped from coverage upon retirement; however, dependents may be added to coverage mid-year only if there is a qualifying event (see **Chapter 11**). Dependents may also be added to coverage during the next Open Enrollment period.

d. The employee has the option to opt out of dental coverage at the time of retirement. If the employee chooses to opt out of dental coverage, the employee will not be allowed to enroll in dental coverage at a later date. Retiring employees can only drop dependent dental coverage if the dependent is being dropped from all coverage. Otherwise, dependent dental coverage may only be dropped at Open Enrollment.

e. Vision coverage may not be dropped at retirement or during the plan year unless due to a dependent becoming ineligible or unless all coverage is terminated. If dependent medical coverage is dropped, dependent vision coverage can be dropped.

f. The effective date of change to the Direct Bill program will be the first day of the

month following the employee's last day in pay status. The SEHP's Direct Bill premium billing vendor will send a Welcome letter to the member with their first bill for the first full month of Direct Bill premiums. This letter also outlines the payment options available to the member.

B. EMPLOYEES, SPOUSES AND/OR DEPENDENTS WHO ARE MEDICARE ELIGIBLE AT RETIREMENT

If the employee or covered spouse/dependent is Medicare eligible when the employee retires, they must have or need to apply for Medicare Part A and Part B. The Social Security Administration requires that the NSE provide retiring employees a memo or letter with health insurance information necessary to process the application for Medicare Part B coverage. When applying for Medicare Part B, the NSE needs to complete **Appendix I** for the employee to present to their local Social Security Office. A sample format is found in **Appendix I** and contains the required information. Please note the letter or memo should be on the Non State Employer's letterhead

Required information in the memo or letter is:

1. Statement that the employee is covered under the SEHP

2. Date coverage began

3. Date coverage ended or will end

4. Spouse's name and Social Security Number if the spouse is covered by the SEHP

C. SPLIT ENROLLMENT

Split Enrollment is required for the following situations:

- When the member and spouse are both Medicare eligible

- When the member is Medicare eligible and the spouse/dependents are not Medicare eligible

- When the member is not Medicare eligible and the spouse/dependents are Medicare eligible

When Split Enrollment occurs, the Medicare member(s) would enroll in one of the following plans:

a. Coventry Advantra PPO with Coventry prescription drug coverage

b. Coventry Advantra PPO with SilverScript prescription drug coverage

c. Humana PPO with Humana prescription drug coverage

d. Humana PPO with SilverScript prescription drug coverage

e. Kansas Senior Plan C with SilverScript prescription drug coverage

f. Kansas Senior Plan C without SilverScript prescription drug coverage

The non-Medicare member remains in one of the SEHP's Plan A or Plan B options. The Non State Employer will need to complete a SEHP Change Form indicating that the employee is retiring and wishes to continue with the SEHP Direct Bill coverage. On the form, the employee will indicate their coverage elections and under the spouse/dependent's information will indicate the coverage election for the spouse/dependents.

Information on these plans can be found on the SEHP website at:
http://www.sehbp.org/state-employee-health-plan-home--2/retireedirect-bill

D. Death of Primary Direct Bill Member with Dependent Children

In the event of the death of a primary Direct Bill member who only had dependent child(ren) covered under their coverage, the surviving dependent child(ren) may elect to continue coverage under the SEHP Direct Bill program until they no longer meet the definition of an eligible dependent (i.e., the child reaches the limiting age of 26).

The eligible dependent child(ren) or authorized representative for the eligible dependent child(ren) must contact SEHP Membership within 31 days of the death of the Direct Bill primary member in order to elect to continue coverage under the Direct Bill program. If elected, the Direct Bill coverage will be set up under the youngest eligible dependent child as the primary member with other eligible dependent child(ren) set up as dependents under that new primary member.

CHAPTER 18 – PREMIUM REFUNDS DUE TO DIRECT BILL MEMBER'S DEATH

I. PREMIUM REFUNDS

The Member enrolled in the Direct Bill program, or a member's authorized representative is responsible for notifying SEHP Membership Services **in writing within 31 days** of a change in family status, including the death of a member, spouse or dependent.

If the member or authorized representative does not notify SEHP Membership Services within 31 days of a change in family status due to the death of the member, spouse or dependent, their premium recovery is limited to the following:

- If SEHP Membership Services is notified after 31 days but within the first 6 months of a death, the member will be eligible to receive a premium refund equal to 95% of the actual monthly premium paid by the member.

- If the SEHP is notified after 6 months but prior to 12 months of a member, spouse or dependent's death, the member is eligible to receive a premium refund equal to 95% of the actual monthly premium paid by the member for the first 6 months, plus a premium refund of 50% of the actual monthly premium paid by the member for months 7, 8, 9, 10, 11 and 12.

***(Example:** If a member's monthly premium payment is $200.00 per month and the SEHP is notified in writing in the 8th month after a death, the member would receive a premium refund of 95% of the actual monthly premium paid by the member for the first 6 months and a premium refund of 50% of the actual monthly premium paid by the member for months 7 and 8 for a total refund of $1,340.00)*

- If the SEHP is notified after the 12th month of a member, spouse or dependent's death, the member will not be eligible for any premium refund.

CHAPTER 19 - CONTINUATION OF COVERAGE - COBRA

I. COBRA CONTINUATION

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) law was enacted in 1986. The law requires that most employers sponsoring Group Health Insurance Plans offer employees and their families the opportunity for a temporary extension of health coverage at group rates in certain instances where coverage under the plan would otherwise end.

Employees, their spouses and dependents that lose insurance coverage under the SEHP have the right to elect to continue coverage by paying the required premiums themselves. (Under COBRA, retirees and those covered through the Direct Bill program have the same continuation rights as active employees.). If a retiree has chosen COBRA over the SEHP Direct Bill coverage and COBRA runs out, the retiree may enroll in Direct Bill coverage.

COBRA continuation is administered through the SEHP's third party COBRA administrator.

Former employees, spouses and dependents eligible to continue health insurance coverage are called **Qualified Beneficiaries**. The provisions under which they can continue coverage are called **Qualifying Events**. The number of months they can continue coverage is specified.

II. HEALTH COVERAGE TO BE CONTINUED

Qualified beneficiaries are eligible to continue only those medical, dental, prescription drug and vision benefits for which they are covered at the time of the qualifying event.

NOTE: If an employee goes on Leave Without Pay, then terminates employment AND does not continue SEHP coverage during the leave period, then that employee and any dependents would **NOT** be eligible for COBRA continuation. They are not eligible because they were not participating in the SEHP at the time of the qualifying event.

III. PROCEDURES TO BE FOLLOWED WHEN EXPERIENCING A COBRA QUALIFYING EVENT

A. If the qualifying event is termination of employment (except for gross misconduct), the SEHP notifies the member's medical plan that termination of insurance coverage has occurred. Because there is a time limit in which the qualified beneficiary can elect to continue coverage, the Non State Employer must notify SEHP Membership Services of terminations of employment immediately so that SEHP Membership Services can terminate coverage.

B. If the qualifying event is the reduction of hours of work to less than 1,000 per year, the SEHP notifies the member's medical plan that termination of insurance coverage has occurred. The Change Form has been designed so that this information can be

recorded on the form. Because there is a time limit in which the qualified beneficiary can elect to continue coverage, upon completion, these forms must be immediately forwarded to SEHP Membership Services.

C. If the qualifying event is because of

1. Death of covered employee (active employee & Direct Bill).
2. Divorce from covered employee (active employee and Direct Bill).
3. Covered employee chooses Medicare as primary carrier leaving dependents without health insurance coverage (active employees ONLY), or
4. Cease to meet the SEHP's definition of dependent, i.e. turns age 26 (active employee & Direct Bill):

The qualifying beneficiary must notify the Non State Employer Human Resources Representative of the employee's Non State Employer **within 60 days** of the qualifying event. (Spouses and dependents of retirees should notify the SEHP **within 60 days** of the qualifying event). If notice is not received within 60 days of the qualifying event, the beneficiary will **not** be eligible for continuation coverage. Because of this time limit, the completed Change Forms must be transmitted immediately to SEHP Membership Services.

D. Within 21 days of SEHP Membership Services receiving notification of the qualifying event, the qualifying beneficiary will receive specific information from the third party COBRA administrator, including a COBRA Enrollment Form setting forth the requirements for continuing insurance coverage, the plans available, and the applicable premium rates.

E. An election by a covered employee or spouse to continue coverage will be deemed to be an election for coverage by any other qualifying beneficiary. However, each qualifying beneficiary has an individual right to select continuation coverage. Each beneficiary may make a separate selection among the levels of coverage available.

IV. TERMINATION OF COVERAGE CONTINUATION

A. Non-payment or untimely payment of premiums;

B. The employee or their dependent(s) become(s) covered, either as an employee or dependent, under another employer-provided medical plan which does not limit or exclude coverage for pre-existing conditions (does **not** apply to the surviving spouse in qualifying event 1);

C. The employee or enrolled dependent(s) become eligible for Medicare (has enrolled in the Medicare program). However, if Medicare eligibility is due to ESRD, the individual may continue on COBRA;

NOTE: **Only the person(s) eligible for Medicare coverage lose(s) COBRA Continuation benefits. Any other person(s) enrolled may continue for the duration of the COBRA eligibility period;**

D. The State of Kansas no longer offers group health insurance to its employees.

V. ADMINISTRATIVE ISSUES

A. SEHP benefits will generally terminate on the last day of the month in which the qualifying event occurs.

COBRA letters are generated by the SEHP's third party COBRA administrator following data entry of the employee's termination action by SEHP Membership Services. If the Termination or Change Form is not processed by SEHP Membership Services, the qualified beneficiary does not receive a letter. Therefore, timeliness becomes a critical issue when completing and submitting forms.

Also, if forms are not processed, the medical plan will not be notified to cancel coverage and claims are paid without collection of premium. **Untimely notification has a severe adverse effect on health insurance rates.**

B. COBRA continuation is not automatic; it is a choice that the qualified beneficiary must make. Also, the Change Form does not activate COBRA continuation status. The qualified beneficiary must complete the COBRA election form that accompanies the COBRA notification letter sent by the third party COBRA administrator. The qualified beneficiary has 60 days from the date of the letter to return the COBRA continuation election form to the third party COBRA administrator.

C. COBRA notification letters will be sent to the qualified beneficiary at their last known address. Therefore it is very important at the time of termination that the correct address is on record with SEHP Membership Services or is submitted on the Change Form. Also, former employees should be reminded to leave forwarding instructions with the US Postal Service in the event of a change of address.

VI. COST OF BENEFITS - COBRA CONTINUATION RATES

Any qualified beneficiary who elects to continue coverage under the plan must pay the full cost of that coverage (including **both** the share they paid as an active employee, and the share paid by the Non State Employer), **plus** any additional amounts allowed by law. At present, COBRA Continuation rates are 102% of total premium. However, those beneficiaries who elect the 11-month extension of benefits due to disability will pay 150% of premium for the additional 11-months of coverage.

For the current Plan Year COBRA rates, see **Appendix Q** or go to the SEHP web site:

http://www.sehbp.org/state-employee-health-plan-home--2/cobra/non-state-employee-medical-plans-cobra

VII. AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009

A. What is ARRA?

The American Recovery and Reinvestment Act of 2009 (Recovery Act or ARRA) was signed into law by President Obama on February 17, 2009. The Recovery Act authorizes up to $787 billion in Federal spending through September 30, 2010. Potential Federal spending includes funding for construction projects in all 50 states, the District of Columbia, and U.S. territories, as well as the procurement of supplies and services. For more information on the Recovery Act, please visit Recovery.gov. Additional information regarding the U.S. Department of Labor's ARRA efforts may be found at www.dol.gov/recovery.

B. What is the new COBRA subsidy provision contained in the stimulus package signed by the President?

The stimulus package, which was enacted as the American Recovery and Reinvestment Act of 2009 (ARRA) temporarily reduces the premium for COBRA coverage for eligible individuals. COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) allows certain people to extend employer-provided group health coverage, if they would otherwise lose the coverage due to certain events such as divorce or loss of a job.

Individuals who are eligible for COBRA coverage because of their own or a family member's involuntary termination from employment that occurred from September 1, 2008 through May 31, 2010 and who elect COBRA, may be eligible to pay a reduced premium. Eligible individuals pay only 35% of the full COBRA premiums under their plans for up to 15 months. The SEHP will fund the remaining 65% of the full COBRA premiums under their plans for up to 15 months. The SEHP then recovers the remaining 65% of the premium by taking the subsidy amount as a credit on its quarterly employment tax return.

C. Who is eligible to receive the COBRA premium reduction?

ARRA makes the premium reduction available for "assistance eligible individuals." An Assistance Eligible Individual (AEI) is a COBRA qualified beneficiary who meets the following requirements:

- Is eligible for COBRA continuation coverage at any time during the period from September 1, 2008 through May 31, 2010;
- Elects COBRA coverage (when first offered or during the additional election period provided by ARRA); and
- The COBRA election opportunity relates to an involuntary termination of employment that occurred at some time from September 1, 2008 through May 31, 2010. Effective June 1, 2010 the COBRA ARRA premium subsidy eligibility ended.

If the individual is eligible for other group health coverage (such as through a new employer's plan or a spouse's plan) or Medicare he/she is not eligible for the premium reduction.

If the employee's termination of employment was for **gross misconduct**, the employee and any dependents generally would not qualify for COBRA or the premium reduction.

D. What needs to be done when an employee terminates?

When an employee is terminated from employment, the Non State Employer Human Resources Representative must complete a Change Form outlining the termination reason.

E. What circumstances constitute an involuntary termination for purposes of the definition of an assistance eligible individual?

An involuntary termination means a severance from employment due to the independent exercise of authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. An involuntary termination may include the employer's failure to renew a contract at the time the contract expires, if the employee was willing and able to execute a new contract providing terms and conditions similar to those in the expiring contract and to continue providing the services. In addition, an employee-initiated termination from employment constitutes an involuntary termination from employment for purposes of the premium reduction if the termination from employment constitutes a termination for good reason due to employer action that causes a material negative change in the employment relationship for the employee.

Involuntary termination is the involuntary termination of employment, not the involuntary termination of health coverage. Qualifying events other than an involuntary termination, such as divorce or a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan (such as loss of dependent status due to aging out of eligibility), are not involuntary terminations qualifying an individual for the premium reduction. In addition, involuntary termination does not include the death of an employee or absence from work due to illness or disability.

The determination of whether a termination is involuntary is based on all the facts and circumstances.

For example, if a termination is designated as voluntary or as a resignation, but the facts and circumstances indicate that, absent such voluntary termination, the employer would have terminated the employee's services, and that the employee had knowledge that the employee would be terminated, the termination is involuntary.

1. An involuntary reduction of hours worked to zero hours, such as a lay-off, furlough, or other suspension of employment, resulting in a loss of health coverage is an involuntary termination for purposes of the premium reduction. If the reduction in hours is not a reduction to zero, the mere reduction in hours is not an involuntary termination. However, an employee's voluntary termination in response to an employer-imposed reduction in hours may be an involuntary termination if the

reduction in hours is a material negative change in the employment relationship for the employee.

2. Involuntary termination includes an employer's action to end an individual's employment while the individual is absent from work due to illness or disability. But mere absence from work due to illness or disability before the employer has taken action to end the individual's employment status is not an involuntary termination.

3. Involuntary termination includes retirement if the facts and circumstances indicate that, absent retirement, the employer would have terminated the employee's services, and the employee had knowledge that the employee would be terminated.

4. Involuntary termination may include involuntary termination for cause. However, for purposes of Federal COBRA, if the termination of employment is due to **gross misconduct** of the employee, the termination is not a qualifying event and the employee and other family members losing health coverage by reason of the employee's termination of employment are not eligible for COBRA continuation coverage.

5. Involuntary termination includes a resignation as the result of a material change in the geographic location of employment for the employee.

6. Involuntary termination includes a termination elected by the employee in return for a severance package (a "buy-out") where the employer indicates that after the offer period for the severance package, a certain number of remaining employees in the employee's group will be terminated.

7. Involuntary termination includes a lockout initiated by the employer. However, a work stoppage as the result of a strike initiated by employees or their representatives does not constitute an involuntary termination.

Once the SEHP processes the employee's termination and identifies the individual as an AEI based on the Non State Employer's termination reason, the individual's information is sent to the SEHP's COBRA administrator.

Normal COBRA notification processes occur. The individual's COBRA notice will include information regarding the 65% ARRA premium subsidy. If the individual who qualifies as an AEI elects COBRA, they will be billed 35% of the total COBRA premium for a maximum of 15 months or until the individual is eligible for other group health coverage (such as through a new employer's plan or a spouse's plan) or Medicare. If a COBRA participant fails to pay their COBRA premium including a subsidized premium, they will lose COBRA coverage and the subsidy.

The SEHP will fund the balance of the 65% of the COBRA premium. Each quarter, the State of Kansas files its employer taxes and will report the COBRA subsidy amount to the IRS for reimbursement from the Federal Government.

Based on current regulation the last month of COBRA ARRA subsidy will end on 8/31/11.

Below is a Subsidy Timelines table showing the length of the ARRA subsidy based on employment termination dates:

COBRA START	ARRA START	MAX ARRA MO	ARRA END	COBRA END
9/1/2008	3/1/2009	12	2/28/2010	2/28/2010
10/1/2008	3/1/2009	13	3/31/2010	3/31/2010
11/1/2008	3/1/2009	14	4/30/2010	4/30/2010
12/1/2008	3/1/2009	15	5/31/2010	5/31/2010
1/1/2009	3/1/2009	15	5/31/2010	6/30/2010
2/1/2009	3/1/2009	15	5/31/2010	7/31/2010
3/1/2009	3/1/2009	15	5/31/2010	8/31/2010
4/1/2009	4/1/2009	15	6/30/2010	9/30/2010
5/1/2009	5/1/2009	15	7/31/2010	10/31/2010
6/1/2009	6/1/2009	15	8/31/2010	11/30/2010
7/1/2009	7/1/2009	15	9/30/2010	12/31/2010
8/1/2009	8/1/2009	15	10/31/2010	1/31/2011
9/1/2009	9/1/2009	15	11/30/2010	2/28/2011
10/1/2009	10/1/2009	15	12/31/2010	3/31/2011
11/1/2009	11/1/2009	15	1/31/2011	4/30/2011
12/1/2009	12/1/2009	15	2/28/2011	5/31/2011
1/1/2010	1/1/2010	15	3/31/2011	6/30/2011
2/1/2010	2/1/2010	15	4/30/2011	7/31/2011
3/1/2010	3/1/2010	15	5/31/2011	8/31/2011
4/1/2010	4/1/2010	15	6/30/2011	9/30/2011
5/1/2010	5/1/2010	15	7/31/2011	10/31/2011
6/1/2010	6/1/2010	15	8/31/2011	11/30/2011

For further information, please contact:

I. SEHP Membership Services at (785) 296-3226
II. COBRAGUARD, Inc. at 1-866-952-6272 or their website at http://www.cobraguard.net/arra
III. Federal Department of Labor's website at http://www.dol.gov/ebsa/COBRA.html
IV. Internal Revenue Services' website at http://www.irs.gov/newsroom/article/0,,id=204505,00.html

CHAPTER 20 - APPEALS FOR EXCEPTION DUE TO NON STATE EMPLOYER GROUP ERROR

I. APPEALS FOR EXCEPTION

Receipt of Enrollment Forms and Change Forms by the SEHP in a timely manner is extremely important. Many enrollment options or enrollment changes are available without restriction for only a limited amount of time from a specific date or occurrence of an event. Any forms not received by SEHP Membership Services within the specified time frames will result in denials or significant restrictions being placed on the employee's enrollment options.

The majority of policies use event date, date completed and date received by SEHP Membership Services as the determining dates for timely notification. It is the responsibility of the Non State Employer Group to ensure that appropriate forms are correctly and legibly completed and the appropriate documentation is submitted in such a way that documents are **received** by SEHP Membership Services within the necessary time frames.

If the employee completes the forms and the Non State Employer Group fails to transmit the forms before the deadline to SEHP Membership Services, the employee will be penalized. If the Non State Employer Group chooses to appeal any restrictions or denials due to untimely processing of forms the Non State Employer Group should:

A. Write a letter to SEHP Membership Services, appealing the denial or restriction that was due to Non State Employer Group error. The letter must include:

- The name and SSN of the employee in question;
- Copies of documentation and forms completed by the employee;
- The nature of the error; and
- Any steps the Non State Employer Group has taken to prevent a reoccurrence of the error.

B. A letter is required for each employee. Acknowledgment of Non State Employer Group error does not provide a blanket exception for all similar circumstances.

C. The appeal must be made by the Non State Employer Group within 10 days following notification of a denial.

CHAPTER 21 - QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN AND HEALTH SAVINGS ACCOUNT

I. QUALIFIED HIGH DEDUCTIBLE HEALTH PLAN (QHDHP)

The Qualified High Deductible Health Plan (QHDHP) is a Preferred Provider Organization (PPO) with a Health Savings Account (HSA) feature. With the QHDHP-HSA, there are both network and non network pricing structures for health coverage. A QHDHP also provides broader nationwide services and there is an allowance for preventive care. While the Preferred Drug List (PDL) is the same for all plans, the amount the member pays will vary depending on the plan that is select as explained below. Under Plan C, the member begins paying copayments for their prescription drugs once they reach the annual health plan deductible. This means that until the member reaches the health plan deductible, the member must pay 100 percent of the discounted cost for prescription drugs. A member can use the funds in their HSA toward these costs.

When a member chooses dependent coverage, the entire family deductible must be met before claims are paid for any one individual. Most covered services are subject to the deductible and coinsurance. See the Health Plan Comparison Chart to see the deductibles, coinsurance and annual coinsurance maximums for Plan C. The preventative care is covered in full as long as the member utilizes a Network Provider.

Prescription drugs are subject to the QHDHP deductible; the vendor ID card will carry the Caremark logo for purchase of medications at a pharmacy. The QHDHP PDL is the same as the other SEHP health plans. In addition, the QHDHP preferred drug plan does not qualify as creditable drug coverage with Medicare. In other words, if a Medicare eligible individual is enrolled in the QHDHP plan, they would incur a penalty when they enrolled in a Medicare Part D prescription drug plan.

II. HEALTH SAVINGS ACCOUNT (HSA)

An HSA is a required part of the QHDHP and has minimum and maximum allowable contributions. The purpose of the HSA is to allow members to put tax advantaged savings aside for future medical expenses. The savings may be used for certain premiums, copayments, coinsurance, deductibles or any medical expenses that are not covered by the QHDHP.

The HSA is owned by the member, administered by the HSA Bank, and can be funded up to the maximum amount determined by the U.S. Treasury Department each year. Members between 55 and 65 can make a”catch up” contribution as outlined in IRS Publication 969. Unlike an FSA, the HSA account is portable and funds rollover from year to year. The funds in the account belong to the member (account beneficiary) and unused funds rollover from year to year.

New employees who enroll in the QHDHP must complete the SEHP Enrollment Form, within 31 days of their date of hire. The SEHP Enrollment Form should be returned to the employee’s Human Resources Office. The member will need to obtain the HSA bank’s enrollment application and submit that form directly to the appropriate HSA bank. The

enrollment applications can be obtained from the SEHP website at:

http://www.sehbp.org/state-employee-health-plan-home--2/choosing-your-health-plan/plan-c-qhdhp-with-hsa/plan-c-contribution-and-banking-information

If the HSA bank enrollment application is not forwarded to the bank, the member will not be able to access the HSA funds that have been deducted from their payroll warrants.

NOTE: If a member selects PHS as their plan choice, the member will automatically be enrolled with Health Equity. Therefore, the member with PHS does not need to complete a Health Equity enrollment application.

Members may change their HSA contribution during the plan year without a qualifying event.

If an employee changes from member only to member and dependent medical coverage or from member and dependent to member only medical coverage mid-year due to a qualifying event, the member may also change the HSA contribution amount. In some cases, the contribution amount will have to change. Refer to the Heath Savings Account Contribution Chart in the Health Plan Summary Booklet.
The member must complete a SEHP Change Form to change coverage level.

ACRONYM GLOSSARY

ACH – Automated Clearinghouse Network

ARRA – American Recovery and Reinvestment Act of 2009

COBRA – Consolidated Omnibus Budget Reconciliation Act

DOL – United States Government Department of Labor

ESRD – End Stage Renal Disease

FMLA – Family Medical Leave Act

FSA – Flexible Spending Account

HIPAA – Health Insurance Portability and Accountability Act

HSA – Health Savings Account

HP – Hewlett Packard

ID Cards – Identification Cards

IRS – United States Government Internal Revenue Service

K.A.R. – Kansas Administrative Regulation

K.S.A. – Kansas Statute Annotated

LWOP – Leave Without Pay

MHPA - Mental Health Parity Act

MSP – Medicare Secondary Payer

NMHPA - Newborns' and Mothers' Health Protection Act

NSE – Non State Employer

PPO – Preferred Provider Organization

QHDHP – Qualified High Deductible Health Plan

SCHIP – State Children's Health Insurance Program

SEHP – State Employee Health Plan

SSN – Social Security Number

TEFRA – Tax Equity and Fiscal Responsibility Act

USERRA – Uniformed Services Employment and Reemployment Rights Act

WHCRA - Women's Health and Cancer Rights Act

STATE EMPLOYEE HEALTH PLAN
ADMINISTRATIVE MANUAL
NON STATE EMPLOYER GROUP–PLAN YEAR 2011
APPENDICES

Appendix	Appendix Title
A-1……..	Kansas Administrative Regulation 108-1-3
A-2……	Kansas Administrative Regulation 108-1-4
B…….....	SEHP Enrollment Form
B-1……	SEHP Enrollment Form Key
B-2……	SEHP Enrollment Form Instructions
C…….....	SEHP Change Form
C-1…….....	SEHP Change Form Key
C-2……..	SEHP Change Form Instructions
D…….....	SEHP TEFRA Form
D-1	SEHP Sample TEFRA Form Letter—Employee Age 65
D-2	SEHP Sample TEFRA Form Letter—Spouse Age 65
E…….....	SEHP Request for Waiver of Thirty Day Waiting Period
F…….....	SEHP Communication Form
G…….....	SEHP Prescription Drug Advance Purchase Certificate
G-1……..	SEHP Prescription Drug Advance Purchase Policy
H…….....	SEHP Caremark Prescription Reimbursement Standard Claim Form
I…….....	SEHP Sample Non State Employer Medicare Part B memo
J…….....	SEHP End State Renal Disease Questionnaire
K…….....	SEHP Dependent Grandchild Affidavit
L…….....	SEHP Affidavit and Application for Coverage of Permanent and Totally Disabled Dependent Child
M…….....	SEHP Affidavit of Common Law Marriage
N…….....	SEHP Staff Contact List
O…….....	SEHP Provider Contact Information
P…….....	SEHP Coverage Begin Dates for Newly Hired Employees
Q…….....	SEHP Plan Year 2011 Monthly COBRA Rates
R…….....	SEHP Specific HIPAA Authorization
S…….....	SEHP Appointment of Personal Representative Form
S-1……..	SEHP Revocation of Personal Representative Form
T…….....	SEHP HP Direct Bill ACH Form
U…….....	SEHP Certification Form